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UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

HEARINGS

BEFORE THE

COMMITTEE ON MERCHANT MARINE AND FISHERIES HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

ON

UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS AND THE HEALTH OF AMERICAN SEAMEN

JUNE 18, 19, 1979—WASHINGTON, D.C.
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UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

MONDAY, JUNE 18, 1979

House of Representatives,
Committee on Merchant Marine and Fisheries,
Washington, D.C.

The committee met at 2:15 p.m., in room 1334, Longworth House Office Building, Hon. John M. Murphy, chairman, presiding.

Present: Representatives Murphy, Mikulski, and Lowry.

Staff present: Gerald Seifert, John Bruce, Paris Russell, and Liz Coker.

The Chairman. The committee will come to order.

This morning we commence hearings to examine the health of these people so essential to our foreign trade and the fourth arm of our national defense; the institutions providing for their health care; and the position U.S. merchant seamen enjoy relative to international health and safety standards now in place or being proposed.

We would like to find out whether a profile of health care needs of merchant seamen exists. Does this medical profile establish seamen as unique? What is the overall view of the seaman's medical care as it relates to international standards? Some have wondered if the Federal Government has operated a medical system for American seamen for 180 years without identifying or documenting even the most basic needs of this unique group.

While at sea, there is necessarily a direct relationship between care delivered and the environmental and occupational conditions aboard ship. Should medicine take cognizance of modern technology, such as ship-to-shore satellite communications, or do we dispense lime juice and hope we reach port before disaster strikes?

The Maritime Administration let a contract to explore the feasibility of such satellite usage to cope with emergency needs between ship and shore. "Project Hope" carried out a ship-to-shore satellite system for an entire year. We are interested in knowing how this was done and the advantages and disadvantages of such new technology. Where does the U.S. Coast Guard stand in setting health and safety baselines in the face of these new developments?

On November 1, 1978, President Carter signed into law the International Maritime Satellite Telecommunications Act. This new law, which I had the privilege of cosponsoring, may help bring about a new era in shipboard health care and raise the standards of health care for our merchant marine. This law certainly opens new vistas that did not exist when we last held oversight hearings on the U.S. Public Health Service hospitals and clinics in September 1978.

As technological advances come on line, I would like to make certain that lack of coordination among the Maritime Administration, the Department of Transportation, and the Department of Health, Education, and Welfare is not frustrating the maintenance and development of the American Merchant Marine. Duplicative efforts are more than wasteful—they frequently serve to contradict one another and result in no progress at all.

The seaman's profile is obviously necessary in order to minister to their health needs. Further, knowing just what constitues seamen's needs may well help in providing care to those who have traditionally been underserved. Ten years ago, Congress made U.S. fishermen performing seamen's duties eligible for USPHS care. Yet, it is estimated that only 30 percent of these fishermen know of their benefits, and perhaps as many as 50 percent never heard of the PHS system, much less their eligibility. It is vital that the PHS system broaden its public information role to respond to this unmet need.

Last August, the Secretary's Public Health Service Hospitals Ad Hoc Committee issued its report. The committee recommended greater community involvement in addition to maintaining its responsibility to the U.S. Merchant Marine. While a noble concept, it must be assessed in light of the fact that these PHS Hospitals have been forced by HEW to operate at levels lower than those which most authorities consider necessary for the provision of adequate health care in the 1970's.

I want to know if this new emphasis on community health care spells an anticipated end of the system as a unique Federal health care delivery system? The directive of the Secretary of HEW to hospital administrators to "voluntarily" submit themselves to Health Systems Agency review is certainly an indicator of a change in planning jurisdiction which may not be consistent with congressional policy concerning the PHS system and the health of certain designated populations. What precisely does HEW view the role of HSA's to be for the PHS system?

In all the talk and concern for the hospitals in the PHS system, little about the clinics has been discussed. It is the purpose of these hearings to fill that information void.

It has become obvious to me that the PHS hospitals constitute a dynamic delivery system against which we can measure overall hospital costs. Since these institutions provide care to real people using real and measurable costs, we should not lose sight of the value the system has in determining cost containment levels. Rather than cost containment based upon intuitively derived standards, would not it be more appropriate to develop a system based upon a viable Federal direct delivery system which we could call "real cost measurement"?

While cost containment or real cost measurement is not the primary role of this hearing or the responsibility of this committee, no one can ignore the impact of health care on our economy.

Since our merchant marine operates in an international climate, each component, including seamen's health, must reflect that reality. It is for this reason that this hearing goes beyond the shore-based hospital and clinic system to a coordinated health system which relies on and builds upon the demonstrated effectiveness of the PHS System.

In the absence of adequate shipboard health, a disabled seaman may have to be beached at a foreign port. This loss necessitates replacement of a crew member and ultimate repatriation. Is this method of delivering health care cost effective, and does this place our U.S.-flag fleet in a favorable, competitive position with the rest of the world?

The standards of health care for U.S. merchant seamen may well determine the future of our merchant marine. We must know how our present and proposed standards and practices compare with those of the International Labor Organization, Intergovernmental Maritime Consultative Organization, and the World Health Organization.

The U.S. Congress is charged with the responsibility of providing care for our merchant seamen. In these hearings, we seek to determine how we are owning up to that responsibility.

At this point I understand we have some Members of Congress present who would like to make a statement.

Congressman Whitehurst, would you like to come forward?

STATEMENT OF HON. G. WILLIAM WHITEHURST, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. WHITEHURST. I will take this seat and not disrupt the gentlemen who have a lot more testimony than I have. If I may, I would like to submit my testimony for the record and just speak very briefly to the salient points in it.

The CHAIRMAN. Without objection, the statement will be made a part of the record at the conclusion of your testimony.

Mr. WHITEHURST. I have a Public Health Service Hospital in my district. I was born and raised in the city of Norfolk. That hospital has been a part of our tradition in that city for many years. It serves not only the merchant seamen who have the need for health care, but also the foreign seamen who are taken ill on the Atlantic Coast near the Virginia Capes brought in there for treatment. It has literally saved countless lives.

I am concerned about the preservation of these hospitals. There was an effort made some years ago to cut them out altogether, and there was a move this year to reduce the funding level by $5.6 million from what has been requested. When one considers the increase in costs will be 12 to 14 percent this year, it is obvious that these hospitals are going to suffer in the quality of health care that they wish to give.

We have had an extensive remodeling program going on in Norfolk. It is about 20-percent complete. Last spring I took occasion to go through the new portion of the hospital, the portion that has been renovated, and I must say it is an improvement, but we have a long way to go.

The thing that impresses me is the role this hospital has taken in the life of the community itself. It has a very close working relationship with the Eastern Virginia Medical School. In fact, the medical school's departments of microbiology and pathology physically are located at our Norfolk hospital. Furthermore, the Tidewater Regional Cancer Network is also located on the grounds of the Public Health Service hospital and provides many services, including centralization of data, unification of tumor board activities and a single cancer registry for Tidewater. This eliminates the need for each hospital or health agency to engage in duplicative services as has been common in other communities.

I could go on and on, but it seems to me it is significant that 5,000 migrant workers on the Eastern Shore of Virginia this summer will, for the first time, have health care provided by the Public Health Service facility there. This has never been done.

As we all know, the care of migrant health workers has been almost unattended in the past, so I am delighted to see these hearings go forward.

As a member of this body who has a hospital in his district and is therefore deeply concerned about its future, I think the work your committee has done and will do in this area will impact very heavily on its continued success, and I thank you for the chance to be here.

[The following was received for the record:]

PREPARED STATEMENT OF HON. G. WILLIAM WHITEHURST

Mr. Chairman, and members of the committee, I appreciate very much having this opportunity to comment briefly on the operation of the Public Health Service system. The nation's Public Health Service hospitals and clinics have enjoyed a long distinguished history, providing excellent health care to merchant seamen, military personnel, and other beneficiaries since 1798. In recent years, however, the Executive Branch has made persistent efforts to phase out the eight remaining hospitals and 26 outpatient clinics. In large measure as a result of your efforts, Mr. Chairman, and the strong interest and support of this entire Committee, it now appears that the will of Congress has prevailed and the PHS hospitals will remain open.

Nevertheless, critics of the PHS hospital system remain within the Administration, particularly at the Office of Management and Budget, and these skeptics continue to bend every effort to deny the PHS hospitals adequate funding. In its fiscal year 1980 budget, for example, the Carter Administration requested $166.4 million for the hospitals. This is a $5.6 million reduction from the fiscal year 1979 funding level. Coming on the heels of this year's rampant inflation, this represents a significant cutback. Moreover, when the funding reduction is compared with the 12 to 14 percent increase in costs anticipated this year at comparable private hospitals, it becomes apparent that the Carter Administration recommendation is wholly inadequate to keep pace with costly advances in medical technology and the other substantial costs incurred by hospitals.

In the case of the Norfolk hospital, located in my Congressional District, I am particularly concerned that the relatively low level of funding will retard the renovation efforts begun in 1975. To date the remodeling is about 20 percent complete. Further renovation is necessary to bring the hospital buildings into full compliance with fire and life safety codes, as well as the Joint Commission on Hospital Accreditation Standards. In addition, the Norfolk facility needs to modernize facilities and provide additional space to accommodate newer methods of patient care and the increased emphasis on ambulatory care and supporting services. It is crucial that this capital improvement program go forward without delay.

I am also anxious that the recent efforts of the Norfolk hospital to participate actively in the local and regional health care system be maintained and expanded. The Norfolk facility has cooperated with the recently established Eastern Virginia Medical School and has made a major contribution to the training of EVMS students. In fact, the medical school's Departments of Microbiology and Pathology are physically located at the hospital. Furthermore, the Tidewater Regional Cancer Network is also located on the grounds of the PHS Hospital and provides many services, including centralization of data, unification of Tumor Board activities, and a single cancer registry for Tidewater. This eliminates the need for each hospital or health agency to engage in duplicative services, as has been common in other communities.

The Norfolk hospital has also begun some promising programs of benefit to the entire community, which should be expanded. For example, the hospital is establishing an alcoholic rehabilitation program which, if adequately funded, could be extended to provide service to individuals who are not PHS beneficiaries. As further evidence of the expansion of its role in the community, the hospital recently negotiated an agreement with the Norfolk Department of Public Health to provide inpatient care to Medicare patients to the extent space and facilities are available. Finally, the hospital has contracted with the Virginia Migrant Health Project to make available care to any of the 5,000 migrant workers who come to the eastern shore of Virginia each summer.

Since I am obviously most knowledgeable about the activities of the Norfolk Hospital, I have focused my comments on this facility. But, I am also aware that similar innovative programs are underway at each of the seven other PHD hospitals. Moreover, the hospitals continue to provide high quality medical care to the traditional PHS beneficiaries against great odds. In view of the constant threats to close the hospitals and the skimpy funds to operate them in recent years, it is truly remarkable that the dedicated PHS physicians and administrators have been able to maintain high standards at such a low cost. PHS hospitals actually have been operating at one-half the cost of many comparable private hospitals. Rather than punishing this performance with further funding reductions, Congress should expand the PHS hospitals' capability and utilize these facilities as models for the entire nation's health care system.

In addition to increasing direct appropriations for the PHS hospitals, Congress should also consider reimbursement for ambulatory care for DoD beneficiaries. This would add about $10 million to the PHS hospitals' annual budget. Approximately $2.3 million of this would go to the Norfolk hospital which last year counted 54 percent of its inpatients and 72 percent of its outpatients as being active and retired military personnel and their dependents. A reimbursement procedure seems particularly equitable in light of the much higher costs DoD would incur if the military personnel were forced to obtain medical care under the CHAMPUS program.

Mr. Chairman, during my six terms in Congress, the PHS hospital system has been under almost constant attack. I am hopeful that the recent report to Secretary Califano by the Public Health Service Hospitals Ad Hoc Advisory Committee, which recommends that the hospitals be maintained and upgraded, will lay to rest, once and for all, the misguided efforts to close, or at least to starve, these health care facilities. There is certainly no doubt about the strong public support for the PHS hospitals in each of the eight communities in which they are located. Nearly all of my constituents consider the expenditures of these federal funds a valuable investment in improved health care. They recognize that not only do the PHS beneficiaries gain from improvements at the hospital, but all of the citizens benefit from the research and training activities and the reduced burden on the physicians and hospitals in the community which result from the hospitals' continued operation.

Once again, Mr. Chairman, I appreciate the strong interest you have demonstrated by holding these hearings. I hope these proceedings will help to focus the attention of the Carter Administration and the Congress on the continuing need to provide quality health care to the PHS beneficiaries and the potential these hospitals offer for serving as models for improvements in the nation's delivery of health services.

The CHAIRMAN. Thank you.

For about 12 years we have been conducting these hearings and they have been, I think, quite helpful in providing focus, to HEW, to the White House, and to the Congress on the effectiveness of these hospitals, both in their communities and in relation to the entire public health care service. They focus on how vital these hospitals are in providing personnel from basic training to across-the-board medical service for health awareness.

Mr. WHITEHURST. You are entirely right. I cannot imagine what we would do in the area of Southeastern Virginia if this hospital were closed. We have 100,000 outpatients who come from East Virginia and South Carolina.

Several years ago when there was a proposal to phase out the hospitals, there was no facility to have taken up the slack. That hospital is an integral part of the health care system in our area.

Thank you very much.

The CHAIRMAN. Thank you very much.

We will recess for just a moment.

[Short recess.]

The CHAIRMAN. Our next witness is Dr. George Lythcott of the Department of Health, Education, and Welfare.

Dr. Lythcott, will you proceed?

STATEMENT OF DR. GEORGE I. LYTHCOTT, M.D., ASSISTANT SURGEON GENERAL, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, ACCOMPANIED BY DR. JAMES ERICKSON, DIRECTOR OF THE BUREAU OF MEDICAL SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; AND RICHARD ASHBAUGH, DEPUTY DIRECTOR, DIVISION OF HOSPITALS AND CLINICS

Dr. LYTHCOTT. Thank you, Mr. Chairman.

I would like to first introduce my colleagues, Dr. James Erickson, Director of the Bureau of Medical Services in which the Division of Hospitals and Clinics exist; and on my right, Mr. Richard Ashbaugh, Deputy Director of the Division of Hospitals and Clinics.

I am very happy to be here today to discuss the current status, as well as the future direction, of the Public Health Service Hospitals and Outpatient Clinics.

As you remember, on January 31, 1978, the Secretary of Health, Education, and Welfare appointed an ad hoc advisory committee to examine the PHS general hospitals; specifically, to review their achievements, to document their current status, and to make recommendations concerning their future use and potential role in the community.

The committee submitted its report to the Secretary on August 31, and recommended that, among other things, the hospitals: First, explore ways in which they could help meet the needs of medically underserved residents in the community, second, develop plans in conjunction with State and local planning agencies, and third, change the overall emphasis of the system to ambulatory, primary, and preventive health care.

I would like today to explain to the committee where we stand in our efforts to implement the committee's recommendations.

On October 18, 1978, Secretary Califano directed the Assistant Secretary for Health/Surgeon General to explore ways in which the ad hoc committee's recommendations could be carried out.

Subsequently, a task force within the Health Services Administration was established to plan the implementation of these recommendations.

The task force's final report is scheduled for presentation to the Secretary in August of this year.

I believe we are on schedule in implementing the ad hoc committee's recommendations. One of the ad hoc committee's recommendations was that the PHS Hospitals should relate closely to community needs and to the planning efforts of local health systems agencies. To implement this recommendation, in each of the eight cities where PHS general hospitals are located, hospital directors have prepared first draft plans to implement the study recommendations.

This effort has been conducted in conjunction with the offices of the HEW Regional Health Administrators, and in concert with health systems agency directors and concerned consumer and provider groups in each city.

Local planning efforts were also initiated to assess how the resources of each hospital could be used to help meet the health needs of underserved populations in cases where other resources are not available, and if necessary, how the resources of each hospital could be integrated into their respective local systems of health care delivery.

In the first week of May, these implementation plans were sent by the hospital directors to the appropriate State and local health planning agencies, and to the appropriate Regional Health Administrators for review and comment. Final implementation plans and all comments from State and local health planning agencies and the Regional Health Administrators are due in my office in July of this year.

Another of the ad hoc committee's recommendation was that the hospitals should become community resources to increase access to primary health care for underserved populations.

How far we proceed in this regard will depend on the reviews of the health planning agencies and the Regional Health Administrators and on budgetary considerations of funding availability and the major costs involved in renovating and maintaining these facilities.

An additional consideration will be the extent to which hospital bed-to-population ratios in cities having a PHS Hospital compare to national planning guidelines. The HSA's and RHA's will have to assess carefully the responsibility for underserved populations of the non-Federal health care delivery systems in cities where favorable ratios exist before making recommendations for use of the hospitals.

In accordance with another ad hoc committee recommendation we have issued detailed guidance to the hospitals for strengthening their patient advisory councils. This will increase both beneficiary and community involvement in hospital-based care.

The ad hoc committee also recommended that research and training priorities at PHS Hospitals be consonant with primary care. Therefore, the following actions have been taken:

Each hospital has been directed to conduct a thorough evaluation of its graduate medical education program in the context of building primary care and maintaining secondary care capacity;

In connection with this evaluation, each PHS Hospital will also review its clinical programs to determine whether the addition of primary care staff may have lagged behind increases in secondary and tertiary level medical personnel;

Each hospital will attempt to offer one or more residencies related to primary care;

Current expenditures of funds for "training integral to residency" will be reviewed, and reallocation of resources made, as needed, to primary care programs;

Funds for training outside the service—TOS—will be used principally to build primary care and to maintain secondary care capacity; and

A period of field experience for up to 2 years will, in general, be required before consideration will be given to applicants for post-residency or fellowship programs.

The ad hoc committee also called for strengthened organization and management of the system. In this regard, you will also be pleased to know that productivity standards to measure cost, clinical effectiveness, and patient acceptability have been developed, approved by the Health Services Administration, and are being reviewed within the Office of the Secretary.

We expect that the baseline data and monitoring system will be in operation by October 1, 1979. We are convinced that management initiatives such as these will help to control costs while at the same time improve the quality of the care provided.

To implement another ad hoc committee recommendation, we have recruited a pool of qualified candidates that includes minorities and women for 15 top management positions.

The ad hoc committee recommended that the hospitals should relate closely to local health systems agencies and should adhere to the same planning guidelines as those established for private sector hospitals. I would like now to address myself to the current and planned relationship of the hospitals and clinics with local health planning agencies.

Prior to the ad hoc committee study, in response to policy guidance from the Health Services Administration, most of the PHS hospitals had established working relationships with the local health planning agencies. On a voluntary basis, PHS hospitals had submitted plans for capital improvements to the local health planning agencies for review and comment.

Federal facilities are not covered by the Health Planning and Resources Development Act for most review processes of Health Systems Agencies.

However, Public Law 93-155, enacted in 1973, expressed the intent of the Congress that the approval of State and local health planning agencies be sought if the executive branch wished to close any PHS hospital or to reduce services below "the level and range" provided by the hospitals in 1973.

Secretary Califano in supporting the major recommendations of the ad hoc committee testified before this committee on September 28, 1978. He stated,

> We will implement an important related Advisory Committee recommendation: The Public Health Service Hospitals should be integrated into local health care systems. The Public Health Service should work closely with the local health planning agencies and apply the same guidelines, quality standards and cost containment measures to the Public Health Service Hospitals that we have established for all other non-Federal hospitals throughout the health planning process.

Further, the Secretary in his October 1978, implementation directive to Dr. Richmond, said:

> You should begin immediately to work with State and local planning agencies to determine the best use of the hospitals' resources in the context of community needs. We should apply the same guidelines, quality standards, and cost containment measures that we have established for the non-Federal sector by the local health planning process.

In summary, then, that is our policy: The hospital directors are expected to work closely with the planning agencies so that hospital services are in accord with the local health systems plan, and plans for capital improvement will be submitted to the health systems agency for review and comment.

Let me now say a few words about our ambulatory care program. It is a dynamic program of outpatient services. We currently operate 27 outpatient clinics throughout the country, other than those located in each of the PHS hospitals. They are located in large cities near coastal areas, on the Great Lakes, and in midwestern ports. These clinics have long been involved in providing community services, and have been in the vanguard in development of ambulatory care models.

The clinics are directed by professional trained administrators, and typically provide services in family medicine, laboratory, X-ray, physical diagnosis, physical therapy, pharmacy, and dentistry.

Each clinic staff varies in size from 7 to 84 full-time personnel. Services are also provided on a consultant basis in orthopedics, gynecology, pediatrics, dermatology, allergy, optometry, social work, psychiatry, et cetera, depending on the needs of the patients.

We are very proud of the quality of the staff. We utilize internal medicine and family practice specialists, as well as nurse practitioners and physician assistants.

The clinics in fiscal year 1978 had over 800,000 patient visits.

The directors of our outpatient clinics have always encouraged community service agreements under the Public Health Service Act. We are currently assisting in community programs to provide child screening, treatment of the medically underserved, and services to urban Indians who do not qualify for Indian Health Service programs. In this regard, we attempt, wherever possible, to secure provider status under medicaid for our clinics.

We have large, modern clinic facilities in Manhattan, Philadelphia, Savannah, and St. Louis. We are in the process of acquiring new leased space, through the General Services Administration, in Chicago, Tampa, San Diego, San Pedro, Calif., and Galveston.

We have acquired expansion space and are in various stages of renovation in Buffalo, Cincinnati, Houston, Jacksonville and Miami. I feel that the physical plants of these clinics will be in excellent condition when these projects are completed.

Their location in inner cities enhances their potential to provide for the medically underserved.

We are also trying to foster an innovative spirit in our clinic program that will demonstrate cooperation and sharing of resources among the programs.

While we are applying modern management techniques to ambulatory care facilities, we are simultaneously upgrading the quality of the care provided. The clinics are operating under comprehensive standards.

In addition, our current ambulatory care—3-year—improvement plan calls for accreditation by the Council for Ambulatory Health Care and the Joint Commission on Accreditation of Hospitals for all clinics with three or more physicians.

This program will place our ambulatory care facilities among a select minority in the United States which have been accredited. Only 132 clinics throughout the country had been accredited through the end of 1978.

Our clinical laboratories are participating in the Center for Disease Control Laboratory Proficiency Testing program, and are working toward certification by that agency. The Savannah PHS outpatient clinic is the only laboratory to have formally applied and been certified; the remaining laboratories should complete this cycle in the next 6 months.

In addition to our hospital and clinic program, we also deliver care to some of our beneficiaries through a contract care system. Currently, we have contracts with 81 hospitals and 171 physicians.

Care is rendered to our beneficiaries through these non-Federal institutions and practitioners when it is not practical to utilize our own hospitals and clinics. In fiscal year 1978 a total of $18,324,000 was expended to purchase such contract care

In regard specifically to Public Law 93-155, I am pleased to say that we are in compliance. The provisions of section 818 of that law basically established four requirements for the operation of the Public Health Service hospital and clinic system:

One, that the eight general hospitals continue to operate in the cities specified in the law.

Two, that the hospital and clinic system continue to provide care and treatment to all beneficiaries authorized under the law at a level and range of services at least as great as what was provided on January 1, 1973.

Three, that the eight general hospitals conduct a level and range of the other health-related activities which is not less than what was being conducted on January 1, 1973.

Four, that the Secretary of HEW may close or transfer control of a general hospital, reduce the level and range of health care activities or change the manner in which they are provided, or reduce the level of health-related activities from the January 1, 1973, level only if the Congress has specifically authorized such action.

As you are aware, Mr. Chairman, since the enactment of that law the Congress has twice requested the General Accounting Office—GAO—to survey the PHS Hospital and Clinic System to ascertain whether or not HEW has complied with this law.

The first occasion was March 1975. This GAO report concluded that the hospital and clinic system was in compliance with Public Law 93-155. A followup report, requested in April 1977, indicated that the PHS Hospital System is attempting to maintain a level and range of direct patient care services comparable with 1973.

We have determined compliance to be met if the man-years of effort expended to provide patient care services is not reduced below the 1973 level.

In 1973 there were 4,614 full-time permanent—FTP—man-years of effort consumed by the hospital and clinic system, compared to an average of 5,537 FTP in 1979 and an estimated 5,295 FTP in 1980. Therefore, the 1980 budget contains an increase of 681 FTP man-years over the 1973 benchmark year.

I would like to conclude my prepared remarks, Mr. Chairman, by saying that I believe our efforts in recent months have resulted in signs of positive change within the PHS Hospital System.

I think you will agree that the change is most significant in the planning effort and the various management initiatives we have undertaken to improve both the efficiency of the system and the quality of care rendered to the patients we serve.

Thank you for your attention, sir. My colleagues and I will be happy to answer any questions you may have.

The **Chairman**. Thank you, Dr. Lythcott.

Dr. Erickson or Mr. Ashbaugh, do you have anything to say?

Dr. **Lythcott**. Not at this time.

The **Chairman**. You talk about full-time permanent man-years of effort, what is that?

Dr. **Erickson**. That is an individual in a position over a year, whether it be one individual or whether it is made up of more than one individual.

It looks at the personnel system to see whether you have all of your positions filled or any given number of positions filled, and so it takes into account the actual man-years of effort.

The **Chairman**. Do you have any way to measure whether these people are cutting grass or performing surgery?

Dr. **Erickson**. This is total staff of each hospital.

The **Chairman**. So there is no denominator in here? The 1980 budget contains an increase of 681 full-time permanent man-years over the 1973 benchmark here. But it could mean a lesser degree of health care?

Dr. **Lythcott**. That is not the case. We have a mechanism to see what these people are doing. We relate it to quality of care and types of activities.

The **Chairman**. In 1975, the Government Accounting Office said you were complying with the 1973 law. In 1977, it said you were merely attempting to comply with it.

Why the equivocation?

Dr. **Lythcott**. I don't know. We were complying. I noticed that language.

I brought it to the attention of my staff. I don't know what GAO meant.

Dr. **Erickson**. I have nothing further to add.

The **Chairman**. Why has it become the policy of the task force to try to get rid of tertiary care?

Dr. **Lythcott**. I think there are several reasons.

First of all, considering the budgetary restraints, tertiary care is expensive. So if you have *x* number of dollars, we like to make them go as far as we can, so we are concentrating more on primary and secondary care.

The second issue is that local health systems agencies, look carefully at the amount of tertiary care supplied in the area. Here is where you get into overlapping duplication in CAT scanners and other things. It is an area we are looking at very carefully because we feel our hospitals can be of most value as providers of primary preventative services, and for secondary care.

The **Chairman**. What about the San Francisco Hospital, with its expertise in plastic surgery? We know the problems of burn victims at sea in shipborne accidents. Here, the probable recommendation would be to get rid of that service. If it had to be purchased on the private medical market, it probably would cost two, three, or four times as much.

There is also the cancer specialty in Baltimore and the eye bank specialty in Galveston. To get rid of the type of expertise that has taken many years to develop seems to me to be pennywise and pound foolish.

Dr. LYTHCOTT. We only asked the health system agencies to evaluate those in terms of what is going out in the system in those areas. Some of the things we are doing that represent tertiary care will be continued, because they happen to be the best in the market.

We do not necessarily intend to stop tertiary care. We intend to look at it carefully and examine further whether we want to go further in the areas.

The CHAIRMAN. Mr. Lowry?

Mr. LOWRY. Thank you.

Dr. Lythcott, do you have comparisons on the demand as compared to the 1973 benchmark that you are measuring constants of service against?

What is the demand of the merchant marine as compared to the 1973 service level? What is the demand of the community clinic for inpatients? Do we have any information on that?

Dr. LYTHCOTT. We have information on demand. You may want me to supply it for the record.

We have charts for the many years in the several categories that exist. If someone has it handy, we can read it off.

[The following was received for the record:]

ATTACHMENT 1

TABLE I.—COMPARISON OF DEMAND ON USPHS INPATIENT SERVICES BY MERCHANT MARINE AND COMMUNITY PROGRAMS, 1973 and 1978

	1973	1978
Discharges:		
American seamen:		
Number	12,453	13.041
Percent	39.7	39.5
Community programs:[1]		
Number	5,020	5,633
Percent	16.0	17.1
All beneficiaries	31,397	32,983
Number of patient days:		
American seamen:		
Number	257,492	218,285
Percent	50.4	47.7
Community programs:[1]		
Number	84,294	72,260
Percent	16.5	15.8
All beneficiaries	510,961	457,932
Average daily patient load:		
American seamen	705.46	598.04
Community programs[1]	230.95	197.97
All beneficiaries	1,399.89	1,254.61

[1] Community programs also include emergencies, special study patients and foreign seamen. Patient days used by foreign seamen in 1973 were 4,201 and 2,811 in 1978.

Source: Data Systems Branch, Bureau of Medical Services.

Attachment 2

TABLE II.—COMPARISON OF DEMAND ON USPHS PRIMARY CARE SERVICES BY MERCHANT MARINE AND COMMUNITY PROGRAMS, 1973 and 1978

Primary care visits	1973	1978
General hospitals:		
American Seamen:		
Number	251,134	272,741
Percent	31.4	30.2
Community programs:		
Number	11,897	59,760
Percent	1.5	6.6
All beneficiaries	798,859	904,206
Outpatient clinics:		
American Seamen:		
Number	219,815	243,196
Percent	28.1	29.7
Community programs:[1]		
Number	6,966	7,121
Percent	0.9	0.9
All beneficiaries	781,547	819,019

[1] Community programs also include emergencies, special study patients and foreign seamen.

Source: Data Systems Branch, Bureau of Medical Services.

Mr. **Lowry**. What is the general trend? Is it increasing or decreasing?

Dr. **Erickson**. The general trend is that the ambulatory levels across the country are increasing; whereas the in-hospital admissions may be up, the length of stays are down.

That stayed about constant over the years. Certainly we know that ambulatory care, which is part of primary care, doesn't totally equal primary care.

It has been increasing slowly but steadily, depending on where you are, and the number of merchant seamen in that particular area.

Mr. **Lowry**. Are we increasing our capability to handle that type of increasing need?

Dr. **Lythcott**. Yes, we emphasized going into primary care facilities. We are looking more toward primary care. We are interested in family practice as opposed to the more esoteric specialties.

We are taking advantage of this general national trend to push primary-preventive care as opposed to secondary and tertiary care.

Mr. **Lowry**. Mr. Chairman, I would like to comment.

I would guess that I have received as many letters on the need for this service, continued service of health care in Seattle, as I have received letters on the Panama Canal. It is a badly needed service.

There is the feeling that we are not appropriating to the level necessary. I would say this is true throughout the Nation.

The **Chairman**. The letters in Seattle on the Panama Canal and the Public Health Service indicated that they wanted the U.S. presence in both places?

Mr. **Lowry**. Yes.

The **Chairman**. Counsel?

Mr. **Seifert**. I would like to pursue your discussion with the chairman.

You said that tertiary care is expensive and that is why you want to look at it carefully. It is also high-profit care in the general sector.

Is that what people in the private sector want most to be protected?

Dr. Lythcott. Yes.

Mr. Seifert. So if you set the fox to watch the chickens, as it were, they would watch it in tune with their own best self-interests. Is that a good general statement?

Dr. Lythcott. That is a good, general statement. I would hope that wouldn't occur. I would hope that objectivity prevailed.

Mr. Seifert. In your statement, you apparently look at the provisions of Public Law 93-155 which says that State and local planning agencies are to approve of any recommendation by Health, Education, and Welfare for closure of Public Health Service Hospitals or reduction in the service, with the final approval being that of the Congress.

Now, you used that very specific requirement, and you extend it to require that the HSA approve everything that is done by a Public Health Service Hospital. That was not provided for in Public Law 93-155. Do you agree with me?

Dr. Lythcott. I do.

Mr. Seifert. How do you make that leap? The fact that it was mentioned, was the only connection between giving HSA jurisdiction and Public Law 93-155, that is, that it must have HSA approval before you can recommend closing.

Dr. Lythcott. It was a policy decision by the Secretary. It is in keeping with the way I think all hospitals should be run.

I would like to see not two systems, not a private system and a Federal system; I would like to avoid the criticism that will come from the private community when we try to show how well we are doing.

If we are following the same rules, regulations, and planning processes as they are, then one gets away from being looked at as a different system.

Mr. Seifert. I understand that.

Does the exemption in the Planning Act apply to Federal hospitals right now?

Dr. Lythcott. Yes.

Mr. Seifert. Is it HSA or HRA that administers the Planning Act?

Dr. Lythcott. HRA.

Mr. Seifert. You communicate with them from time to time, I assume?

Dr. Lythcott. Yes.

Mr. Seifert. If the Veterans' Administration hospitals and the Department of Defense hospitals are exempt, and they are part of the Federal health care system, what kind of a strange animal does that make you?

Dr. Lythcott. You are correct; it makes us a strange animal. I would hope that the VA and DOD systems would examine themselves and come up with the same direction. I happen to believe very firmly, although it was not my policy originally, in the position the Secretary took.

I am not afraid of being done in by the health systems agencies.

Mr. SEIFERT. Does HRA communicate with the HSA's over whom they have some jurisdiction? Public Law 93-155, requires that HRA consult with the HSA's concerning the planning responsibility concerning Public Health Service Hospitals. Are HSA's aware of the provisions of Public Law 93-155?

Dr. LYTHCOTT. I am sure. The regional offices are responsible. There are not only people from our own shop, but people from HRA as well. They have been an integral part of the whole implementation system.

There also has been representation of HRA on our internal HSA Committee.

Mr. SEIFERT. I am going to read to you a transcript of a news broadcast, which appeared on KPIX channel 5 in San Francisco, Friday, June 8, by Mr. John Hamilton of HSA, West Bay Health Services Agency. These were his comments:

> There are those who make us feel like Hatchet Men when all we are trying to do is be consistent with our own policies and established guidelines for all other hospitals. We require a "certificate of necd" for any care provided, especially tertiary care which we view as over-extended to the community by all the hospitals. If the PHS hospital is to be involved in the community then it must come under the same constraints as the other hospitals. They cannot be equal and unique at the same time.

Does that statement and expression of policy of HEW pertain to both HSA as well as to HRA?

Dr. LYTHCOTT. I thought you said this was a person from the HSA in California?

Mr. SEIFERT. Yes, I know they are independent. They are community-based organizations, are they not?

Dr. LYTHCOTT. Yes.

Mr. SEIFERT. You have entrusted them with the responsibility of first-cut planning. Will you rely on their recommendations?

Dr. LYTHCOTT. Yes.

Mr. SEIFERT. If this is the attitude of the local health planners, I am forced to assume one of two things: I have to assume either that they are ignorant of the provisions of Public Law 93-155, which includes PHS Hospitals, or that they are expressing a change in philosophy of HEW; which one is it?

Dr. LYTHCOTT. It is a change in philosophy of the Department of Health, Education, and Welfare. We have agreed this is the way we would like to go, sir.

Mr. SEIFERT. So you do want to phase out tertiary care?

Dr. LYTHCOTT. Not phase out. I was relating it more to the involvement with the HSA.

Mr. SEIFERT. Would it be your considered opinion to close some of the teritary care activities in the Public Health Service hospital in San Francisco if the West Bay Health Services Agency recommended such closures? Would you go along with such a recommendation?

Dr. LYTHCOTT. I would have to listen to it very carefully. We would have to negotiate positions. Some of our tertiary care will perpetuate itself, because it happens to be the best in the city.

I would take a chance that we would get a low blow from the health systems agencies, but at the same time I would negotiate it out if it were not done properly.

Mr. Seifert. What procedure would you follow if a recommendation comes in from a HSA to close a hospital?

Dr. Lythcott. We are supposed to receive a set of recommendations from HSA's and from the HRA. We will react at that time.

I don't look at it as a confrontation between us and them. I look at in terms of a participatory activity in which all hospitals ought to be involved.

Mr. Seifert. I am not suggesting an adversary policy. If a recommendation for closure were made by HSA, what would your direction be?

Dr. Lythcott. The administrator of the hospital would be involved. I would get his candid view. He would know the local health system, and what other kinds of activities this might be duplicative of, and in the central office, we would take it under consideration and make a final judgment.

Again, I would insist that we be allowed to negotiate with the HSA with respect to a particular activity.

Mr. Seifert. The primary goal of the system has been to a particular segment. We are meeting in this room that is dedicated to that particular service, the merchant marine. Do you believe that merchant seamen, in light of changes which are coming about within HEW, are still required and should receive priority treatment?

Dr. Lythcott. I do, sir.

Mr. Seifert. Do you see any conflict between the change in scope or in thrust of the delivery system and that goal?

Dr. Lythcott. I do not see any conflict. What I do see positively is a justification even in the most dour eyes, of maintaining the system.

I have a problem with diminishing numbers over the long run and maintaining a system unless one can use it to assist others in need in the general area.

Mr. Seifert. In that respect I find it interesting that in the testimony that has been submitted and that will be given tomorrow by Mr. Clark and Mr. Simpkins of the Labor Management Maritime Committee, there is an indication that although as a percentage there may be drops, the same numbers of seamen are being served now as were served in 1972, 1970, and 1967. But there is a problem related to this particular segment of the population which gives us some problems. I do not know whether you have observed the same thing. But I will give you a copy of Mr. Clark's testimony. It has an interesting comment on the back which indicates just what I am talking about now.

You talk about a decline in utilization by this particular beneficiary group, while in actuality there has not been, even though there may have been a drop in the total number of seamen going to sea. That is what you are looking at. I think it is a paradox if there is a drop in the number of men going to sea and yet the same number of people from that population group utilizing the facilities of the Public Health Service Hospital System.

Does that mean you are not paying adequate attention to the unique needs of this particular group? Is that a possibility?

Dr. Lythcott. I do not think it is. I would like for Dr. Erickson to respond.

Dr. **Erickson**. I do not think it is. When I was director of the Seattle Public Health Service Hospital, I was concerned because of the drop in the number of merchant seamen from 1970 to 1975. We were providing the same level of care. It had gotten even larger and better. I went down to the unions and talked to them and found out that the number of seamen in that area had dropped as the Vietnam war wound down. You have fluctuations that are more than seasonal. They are over long periods of time.

In Seattle, our primary care load was only 35 percent of the inpatient population where it had been higher in the years prior to that—1971–72.

Mr. **Seifert**. Does the fact that the average age of the merchant seamen approaches 50 give you any problems?

Dr. **Erickson**. It means we have to become more aware, and I think we are, of illnesses that strike that age population at a higher frequency than a younger population.

Mr. **Seifert**. Is there not a relationship between your ability to deliver primary and secondary care and your ability to develop tertiary care systems that concentrate on very vital areas? Should that not be related to your prime beneficiary need?

Dr. **Erickson**. In looking at our total coverage, as Dr. Lythcott says, we are not out looking to close anything. We are going to take a hard look at adding things. Certainly the vast majority of patients who see us are those who need primary and secondary care, and that is true wherever you are.

The Federal sector is also concerned about the sharing of services, particularly tertiary services, such as CAT scanners. We are not here to say that any tertiary care, such as renal dialysis or pulmonary cardiac labs, will be closed tomorrow. The HSA should know we are operating a system and not simply a local hospital.

Mr. **Seifert**. It was the renal dialysis system in San Francisco that was under attack. It is quite interesting.

Dr. **Erickson**. Yes.

Mr. **Seifert**. Yes, because it received plaudits and high marks for providing service, not only to the primary beneficiary group, but to the entire community.

Now, the Ad Hoc Advisory Committee made certain recommendations and implementation has been held up on many of these recommendations pending the completion of some studies, correct?

Dr. **Lythcott**. No, sir. I think we are on target, pending review and comment by the local health systems agency and the Regional Health Administrator. Once we get their comment, a review of the report from the hospitals individually, that will be submitted to the Secretary for final response. Nothing is being held up, sir.

Mr. **Seifert**. Why has HEW not requested money for modernization beyond the amount in the Carter bill? This question was addressed to the Secretary back in March in the Health Committees. The answer that came back in April of this year was that the "the Public Health Service hospitals Ad Hoc Advisory Committee recommended capital improvements * * * August 30, 1979."

[The following was received for the record:]

Maintenance Costs

Question 6. What is the cost of maintaining the physical plants of the PHS system?

Answer. The Division of Hospitals and Clinics is preparing a recalcuation of the Oklahoma University/Veterans Administration formula for determining the cost of maintenance of the hospitals and their outbuildings. This report is to be completed in the near future and will be forwarded to your office at that time.

Question 6a. What would be the annualized cost if sufficient funds were obligated for modernization and renovation?

Answer. The original estimate which was submitted to the Congress in January 1977 was that it would cost $120 million to modernize and renovate the PHS hospital system. The Congress appropriated $15 million for repairs and improvement in fiscal year 1978. The most recent revision estimates that it would cost $88 million to complete all appropriate projects over a five-year period.

Question 6b. Why has HEW not requested monies for modernization beyond the $3 million for Carville?

Answer. The PHS Hospitals Ad Hoc Advisory Committee recommended that the capital improvement plans of each hospital be revised in accordance with the review of the hospital's role by the local health planning agency. These reviews and resultant revised mission statements are expected to be completed by August 30, 1979. At that time further adjustments in the expected cost of modernization may be expected. These costs will consider the continuing requirements to comply with the life safety, fire codes and JCAH standards, in addition to any costs associated with changes in policy direction.

Mr. SEIFERT. Earlier, it was said these would be completed by April of this year. The reason the question was asked was that it had been originally indicated by HEW that any supplementary work necessary to fully implement the recommendations or to reject the recommendations of the Ad Hoc Advisory Committee would come earlier so as to be considered in the current budgetary process.

Why is it necessary, when we are talking about HEW considering the recommendations of its own Ad Hoc Advisory Committee, that you have to go to HSA and wait for their recommendation?

Dr. LYTHCOTT. You have taken it to the absolute extreme. That is not the reason it is being held up. It is not held up just to allow the HSA to take a position on this. It is part of a total process and the total process involved in this. It was not the decision to have the HSA tell us what to do.

Once we embarked upon the course to get the hospital, its staff and its Director and the HSA and the RHA position, we thought it important to pursue it to the end rather than frustrate the efforts of the people who worked so long and so sincerely to get a job done.

Mr. SEIFERT. I am referring to a memorandum, dated October 18, from the Secretary. It is a memo to the Assistant Secretary for Health.

It reads,

> We also need to assess whether direct delivery is the most effective way to provide health services to seamen. I believe we must do a comprehensive cost-benefit analysis in view of the number of competing priorities for increasingly scarce health dollars. You should work with the Assistant Secretary for Management and Budget to provide me in 60 days with a report of the costs of direct provision of health services to primary beneficiaries compared with purchasing those services in the private sector.

That is signed by Joseph A. Califano, Jr.

Dr. LYTHCOTT. Right.

Mr. SEIFERT. That was October. This is June. The studies are not yet in?

Dr. **Lythcott**. There are no other studies that I know of. You are very correct, sir. That study has not come to its conclusion. That is a very difficult study to design and much of the time has been spent in honest deliberation among men of good will in an effort to design it. It is being looked at from the point of view letting it out to competing contractors.

It is in the Assistant Secretary's office and it will go out to contract soon. It is a difficult study to get together. We did not want to do it on an ad hoc basis. You are quite correct. It is late.

Mr. **Seifert**. I am glad that you knew what I was talking about anyway.

How do you view the idea of using Public Health Service hospital costs as the basis of measuring the cost of health care in the community generally? The chairman in his opening statement, posed the possibility of using an in-place, comprehensive delivery service as a basis for comparing costs in the health care community generally.

Does that strike you as being logical?

Dr. **Lythcott**. You have to be careful. It is like comparing apples and oranges. It is difficult. It can be done if one weights it properly, but not easily.

Mr. **Seifert**. I am glad to hear you say that. That should be true about the way the Public Health Service's Hospital is viewed in terms of community relationships and how HSA views it. I do not think that the West Bay HSA from the KDIX broadcast is aware that there is anything different about the Federal delivery health care system from the private or voluntary system. There are needs in these hospitals, are there not, which cannot be served by a community-based institution?

Dr. **Lythcott**. There is no doubt. I would certainly hope that the HSA would not take the view that you have mentioned.

Mr. **Seifert**. Do you think that it is the role of your administration to inform them through HRA or directly?

Dr. **Lythcott**. Yes.

Mr. **Seifert**. That there is a unique need which the Secretary still agrees with Congress concerning direct Federal health care delivery by way of the public health system?

Dr. **Lythcott**. That is true. I would hope we would continue to point out the differences in services offered by the Public Health Service Hospitals and Clinics.

Mr. **Seifert**. Are you considering requesting congressional approval to close or recommend reduction in any of the facilities which are protected by Public Law 93-155?

Dr. **Lythcott**. As the Administrator, I have not looked critically at any of the recommendations that have come in. I do not consider it a complete document until the other participants have had their 2 cents to say. I have no plan to recommend closure. I have seen nothing for or against it.

Mr. **Seifert**. I was thinking of within your house.

Dr. **Lythcott**. Within our own house, sir, we have not considered closing any hospital. We did read the recommendations of the Ad Hoc Committee that the Secretary appointed and in one hospital it was suggested that its direction be changed, but it certainly did not suggest that it be closed.

Mr. Seifert. In the Great Lakes there are 4 PHS Clinics, 29 non-Federal contract hospitals, and over 50 physicians under contract to serve primary beneficiaries. The system in the Great Lakes is backed up only with a remote hospital.

Dr. Erickson. That is right. There is no hospital in the northern Great Lakes area.

Mr. Seifert. Do you do any cost comparisons among those various modes of delivering care?

Dr. Erickson. We do some comparisons. As you know, a study was done sometime ago, an overall comparison. We have not done any recent cost comparison studies vis-a-vis cost of care in our clinic as opposed to contract care on the outside. As you know, the reason we contract for care with a physician is because it is in an area where the volume would not suggest that a Public Health Service Clinic be mandated at this point in time. We do not have contracts for a specialty unless it is for a specialty which we cannot provide.

Mr. Seifert. So you are not talking about comparable service?

Dr. Erickson. No.

Mr. Seifert. You only have four clinics up there in the Northern Great Lakes?

Dr. Erickson. Yes. But they have primary care staffs and the only local contracting physicians would be specialists such as Dr. Lythcott mentioned in his testimony—orthopedists, et cetera.

Mr. Seifert. So you cannot look to them for any cost comparison?

Dr. Erickson. I do not think so. The only comparison is a remote contractor in a small town where there is only an occasional seaman who comes by his door.

Mr. Seifert. Since the seeds of an HMO exist in every Public Health Service Hospital, such a change could be a way in which they could well serve the community and defray some of the public's costs. This was, in fact, one of the recommendations of the Ad Hoc Advisory Committee.

It is impossible for a hospital to do so without legislative authority. Are you going to recommend any legislation which would permit a Public Health Service Hospital to serve as an HMO?

Dr. Lythcott. We will look closely.

If we make such a recommendation, so be it. The review processes are difficult and intricate. It is certainly possible that a Public Health Service Hospital could be an HMO.

If you include large sections of the poor in a given area, this would mitigate against an HMO arrangement, because the poor are not able to make a prepayment and so forth and so on.

We are looking at it. If it seems to be the way to go, we will make that recommendation. As they sit, without legislative change of several kinds, it will be difficult to convert hospitals into HMO's.

Mr. Seifert. You are not suggesting that HMO's would become hospitals for the poor?

Dr. Lythcott. No, I was not saying that.

I was saying that the general trend, and the recommendation of the Ad Hoc Committee originally was, that the hospitals should involve themselves with those who are underserved in their particular communities; and if they can do this with the same staff, and so forth and so on, and help assist in delivery of health care, they are doing a yeoman's job.

Mr. SEIFERT. You talk about the underserved. You don't mean to say that you are underserved if you are incapable of buying a level of care, do you? Is that necessarily true?

Dr. LYTHCOTT. There may not be anybody there even if you can buy it.

Mr. SEIFERT. They may not be aware of the availability of services?

Dr. LYTHCOTT. Absolutely.

Mr. SEIFERT. That is the case that exists with fishermen who are, in many instances, primary beneficiaries. Apparently they are underusing the Public Health Service's facilities, and there is some question as to whether they are aware of the availability of clinics and hospitals.

Dr. LYTHCOTT. Counsel, that is a criticism one could make about the health care system in general; and our health care system is not exempt.

There are things we do to improve the dialog.

Mr. SEIFERT. But we are the Public Health Service. There is something unique which should establish standards a little higher than the private voluntary sector, don't you agree?

Dr. LYTHCOTT. I agree.

Mr. SEIFERT. I think the Public Health Service System has a special responsibility. "The recruitment and retention of adequate and competent staff is the most crucial problem facing the hospitals. Staff ceilings must be eliminated."

This was a specific recommendation of the Ad Hoc Committee. A little while ago you were discussing with the chairman of the committee that you look at ceilings, and it could be doctors or groundskeepers, as long as you are maintaining the numbers in place on January 31, 1973. Everyone looks at these figures and says we are doing a great job because we have even more slots now than there were in place on January 31, 1973.

How does this relate to the recommendation of the Ad Hoc Advisory Committee? Because staff ceilings must be eliminated, or they will pose problems for retention.

Dr. LYTHCOTT. The Agency does not make decisions about overall personnel ceilings. But within the context of Public Health Service Hospitals and Clinics, once a judgment has been made how to go, we will seek to maximize the number of personnel we have.

We will go to other multihospital systems and see what they are doing, and ultimately, if necessary, go to the Department and ask for additional ceilings.

That is a judgment made for us, not by us.

Mr. SEIFERT. Don't the recommendations start with you, sir?

Dr. LYTHCOTT. They start with us. Yes, of course. I make my recommendations, as you know, to the Assistant Secretary. Then it goes to the Secretary and then to the Office of Management and Budget.

Mr. SEIFERT. Now, cost containment.

Of the recommendations made by the Ad Hoc Advisory Committee, those which relate to cost containment, like on oilspill, came to the very top.

The HSA program had its roots in cost containment programs growing out of the initial participation in medicare-medicaid. Yet it was observed by the Secretary, in response to a question posed by the chairman, that in exchanging services with DOD hospitals, you participate in what he called an equitable exchange system.

It turns out, however, that the Public Health Service loses $10 million each year because you provide them $18 million worth of service, and they provide you with some $8 million.

I can give you——

Dr. LYTHCOTT. I am familiar with what you are saying, sir.

Mr. SEIFERT. Is there anything that is being done to rectify this imbalance?

Dr. LYTHCOTT. We are looking at that right now. I would like Dr. Erickson to give you the historical perspective.

Dr. Erickson, do you want to respond to that?

Dr. ERICKSON. Yes, thank you, Dr. Lythcott.

Historically, the decision was made among the various agencies, the Public Health Service and the various other agencies including DOD, that they would not charge each other for ambulatory care.

We reimburse standard interagency rates for inpatient care, but not for any ambulatory care. I understand that was developed because the workload involved to do the mechanical accounting and so forth in a sense would not be worth the effort for the numbers involved.

We are taking a second look at that. Historically, that is the way it was developed. We will not charge one another for ambulatory care.

You can come to mine, and we can go to yours. The dollars are different because there are more of them than there are of us.

Mr. SEIFERT. Would you keep the committee informed of the progress you make on this?

Dr. ERICKSON. Yes.

Mr SEIFERT. Thank you.

Mr. HUGHES [presiding]. Mr. Lowry from Washington, do you have any questions?

Mr. LOWRY. Thank you, Mr. Chairman.

Before you came in, I had asked some questions.

Dr. Erickson, you are from Seattle?

Dr. ERICKSON. Yes.

Mr. LOWRY. Is that facility being utilized completely now as far as the facility goes, or is the staff not enough to utilize the facility?

Dr. ERICKSON. The facility is being utilized. The last time I was there, the facility looked busy enough, and so did the staff.

I don't know of any spaces not utilized. We are working with primary beneficiaries and the Indian Health Service because they have no hospital.

They are another part of the Health Services Administration. It is my belief that that hospital is being utilized.

Mr. LOWRY. Our information from the community is different from that. Our information is that there are empty beds not being utilized because they are understaffed, that the job has not been done because of the type budget holding down the staff.

I would appreciate it if you would check into that and get information back to the committee and to me on that.

Dr. **Erickson**. Yes, sir.

[The following was received for the record:]

Operating Capacity of the Seattle PHS Hospital

At the present time the Seattle Public Health Service Hospital is operating at both its inpatient and outpatient capacity. While the hospital has an official inpatient bed capacity of 220, it has an effective operating capacity of 152. Based on workload experience on the inpatient wards as well as published projections of nursing patient care hours, the 102 full-time permanent nurses at the hospital can care for about 120-125 patients. The remaining capacity is provided by using part-time and intermittent personnel.

The inpatient census at Seattle is strongly influenced by the ambulatory care programs of the hospital. The objective of a primary care/preventive care program such as Seattle's is keeping people well. If they do require care, however, the preferred mode of treatment is ambulatory care (assuming that acute inpatient care is not mandatory for the condition), since ambulatory care keeps the patient in a familiar and supportive environment and is more cost effective. If a hospital provides good primary care, its inpatient utilization should be lower. This is the thrust of the program at Seattle.

From this point of view, the need for inpatient capacity can be correlated to the size of the outpatient population served, although the exact relationship may vary among hospitals. The ratio at Seattle over the last four years has been one admission per 25.2 clinic visits. At present Seattle is at its physical capacity for outpatient workload. Increases in inpatient utilization cannot be projected until outpatient capacity is increased or referrals from other HEW sources in Region 10 (mainly Indian Health Service and Public Health Service contract care physicians) are increased.

Mr. **Hughes**. Does the gentlewoman from Maryland have any questions?

Ms. **Mikulski**. No, Mr. Chairman.

In looking over the remarks that you covered, that pretty well answered my questions.

Mr. **Hughes**. Counsel?

Mr. **Bruce**. Just one question by way of reassurance.

Will there be any adverse effect to the primary beneficiary as a result of your expanded regional health service?

Dr. **Lythcott**. No. We have as a primary focus the merchant seamen in this system of hospitals and clinics. Anything else is an add-on. It will not replace our interest and enthusiasm.

Mr. **Bruce**. There has been discussion of consulting with HSA. Do you have consultations with representatives of primary beneficiaries?

Dr. **Lythcott**. We have, indeed, done just that. The unions, and the other maritime groups, have been involved all the way from the earliest days of the Ad Hoc Committee. They sat in on hearings, and were questioned, and even sat with the implementation committee. So we are in close contact with the organized consumer groups, as well as HSA's, and the regional health administrators.

Mr. **Bruce**. Is there any danger that an individual—I am talking about the regional health center concept—is there any danger that an individual may apply for Federal aid through many programs? Is there a danger of duplication of cost?

Dr. **Lythcott**. I don't think so. I would like to investigate that a little more.

Off the top of my head today, I don't see that that would be a problem.

Mr. **Bruce**. This question has been asked before in previous hearings. Since you see a need to serve the underserved with

Public Health Service, what thought has HEW given to the expansion of that program to serve the underserved?

Dr. LYTHCOTT. You mean the Public Health Service Hospital System?

Mr. BRUCE. Or the Regional Health Care Service Centers; whatever you want to call it.

Dr. LYTHCOTT. I have not. I don't believe the Department has. I gave it no consideration. We are adding and supporting health care in other ways, using community health centers in many areas of the country.

That is the direction.

Mr. BRUCE. You have an unused facility in Detroit, Mich.?

Dr. LYTHCOTT. Yes.

Mr. BRUCE. Which you tried to turn over to the community?

Dr. LYTHCOTT. Yes.

Mr. BRUCE. And they were unable to absorb it?

Dr. LYTHCOTT. Yes.

Mr. BRUCE. And that building is still there?

Dr. LYTHCOTT. Yes.

Mr. BRUCE. Unoccupied?

Dr. LYTHCOTT. Yes.

Mr. HUGHES. Thank you very much, Dr. Lythcott, Dr. Erickson, and Mr. Ashbaugh.

Dr. LYTHCOTT. Thank you.

Mr. HUGHES. Our next witness is one of our distinguished colleagues, Barbara Mikulski, the gentlelady from Maryland.

We are happy to welcome you as a witness. Without objection, we will accept your full statement for the record at the conclusion of your testimony. You may proceed in any way you desire.

STATEMENT OF HON. BARBARA MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Ms. MIKULSKI. Thank you. I would like to submit my full statement for the record, but I would like to make a few comments.

No. 1, I would like to affirm the need for special services to the merchant marine and American seamen through the Public Health Service System.

We have, I think, a social contract to the American Merchant Marine that was really established primarily through World War II. When we think of these services provided to this country by the Merchant Marine during wartime to carry freight, whether it was World War II, the Korean war, or Vietnam, they, in effect, served this country as a quasi-military unarmed force, and I think by both tradition and statutory measures, we made a social contract with the American Merchant Marine that we were going to provide them with health care pretty much as we provide veterans with health care through the Veterans' Administration.

The analogy is similar. I reviewed the Ad Hoc Advisory Committee's Report to the Secretary. The Public Health Service hospital in Baltimore is already in many ways meeting the recommendations made to the Secretary by this special committee, and I would like to share with our own committee the results of that.

No. 1, we are meeting continually our statutory obligations by providing health care services not only to the current American

Merchant Marine service, but a great deal to the retired merchant marine seamen.

There are many men who sailed the seas during the Korean war and World War II in the late sixties and early fifties who need specialized medical care and are receiving it at this hospital. Many are already retired.

My statement for the record carries statistics.

The population at risk here is an aging one, and requires particular medical attention, No. 2, and basic primary care; and No. 2, in specialized geriatric care. That is the kind of service we provide.

We are doing primary care, and also providing special services to meet our statutory obligations. We have a geriatric treatment center and a psychiatric treatment center. We have a multiphasic screening clinic, which deals with someone who has had a stroke, and a whole host of other things.

But in addition to providing direct medical care, we are also a teaching hospital in Baltimore associated with Johns Hopkins, and the University of Maryland, and that way we are able to bring the best and brightest of medical students to provide health care; and at the same time, they are exposed to a population that they would not ordinarily see.

In addition, Baltimore is a unique community, because, as the report describes us, we are overbedded and physician-rich. That means we have a lot of hospital beds and a lot of doctors.

But like so many urban areas, our doctors are moving out to the beltway where it is convenient to fancy, new hospitals. They have the latest in CAT scanners and whatever is the current fad in medical technology. And even though we have a lot of doctors in the metropolitan area, there are targets in Baltimore that are tremendously underserved.

The area around Johns Hopkins, within the shadow of the Public Health Service, is one area that is underserved. The Baltimore Public Health Service Hospital is serving the community of Camden-Woodbury, and they are providing primary care and meeting a unique and special role in the primary care delivery in that area.

So what I wanted to bring out is that if we follow the recommendations made in the special report to the Secretary, I think we can do two things:

We can meet our moral obligations to the American Merchant Marine by providing health care to them; and by the very nature of their geographic locations and the other communities abandoned by beltway medicine, we can also provide Federal health care in a way that does not create new institutions; does not create new bureaucracy, new personnel, but makes very creative use of people and resources to serve Americans.

So I would like to endorse these recommendations. I want to keep all the Public Health Hospitals open, and I would hope you would look at Baltimore as a national model to see how some of these recommendations are working.

That concludes my testimony. I would be happy to answer any questions that the committee would like.

Mr. HUGHES. Thank you.

Do our colleagues from Washington have any questions?

Mr. **Lowry**. I would just like, Mr. Chairman, to thank our colleague for that statement. We have a Public Health Service hospital in Seattle. I would like to second what you said. You said it much better than I could ever say it.

Your point is directly on the need for service to the underserved, and the need to make sure that we meet our primary responsibility. I would like to have the privilege of concurring with your comments and saying thank you.

Ms. **Mikulski**. Thank you.

Mr. **Hughes**. Counsel?

Mr. **Seifert**. No questions.

Mr. **Hughes**. I would like to echo the sentiments of my colleague from Washington. It is a very fine statement. We appreciate your contribution.

[The following was received for the record:]

STATEMENT OF HON. BARBARA MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND.

Mr. Chairman, I welcome the opportunity to appear before my own subcommittee in support of Public Health Service hospitals

It, is, in fact a privilege for me to appear on behalf of the Public Health Service hospital which is located in Baltimore. This facility has the distinction of being known for the excellent quality of health care which it provides. Last year 35 percent of the patient population discharged were American seamen, Coast Guard, PHS and NOAA, while 40 percent were Department of Defense personnel and other statutory beneficiaries. Over 17 percent of the patients seen in the outpatient department of the hospital during the last year were American seamen, Coast Guard, PHS and NOAA; while 78 percent were Department of Defense personnel and other designated beneficiaries.

As a teaching hospital, the inpatient services provided include a long list of medical specialties, surgical specialties, dental specialties as well as other adjunct and supporting specialties. Outpatient services include primary care, geriatric and psychiatric treatment centers and a multiphasic screening clinic.

Our PHS has the added benefit of being affiliated with Johns Hopkins and the University of Maryland which allows us to provide approved residency programs in internal medicine, general surgery, and preventive medicine. Ophthalmology and dentistry are now offered as independent residency programs. In order to meet the needs of its surrounding community, the hospitals services have been extended to patients affiliated with community programs and emergency nonbeneficiaries, who have accounted for as much as 5 percent of outpatient visits and 25 percent of the discharges.

Among the special programs offered, the alcohol detoxification unit and the psychiatry and geriatric day treatment centers are freely used by community residents as well as statutory beneficiaries. Over 30 service agreements and at least 25 training affiliations with community organizations have been established.

Based on a report to the Secretary of HEW on Public Health Service hospitals, Baltimore's hospital clearly stands in the forefront of health service delivery because of its innovative approach and ability to reach out into the community in a spirit of cooperation.

Despite the high quality of health and mental care given at the PHS in Baltimore this facility faces the same problem as other PHS hospitals. There is a constant fear that inadequate funding and staffing ceilings will make it impossible to maintain the PHS system. Mr. Chairman, we need this hospital, we cannot afford to allow it to starve from inadequate funds or transfer the jurisdiction to other government entities which do not have the financial capability to keep it going.

Mr. **Hughes**. The next witness is Dr. Cecil G. Sheps, Professor of Social Medicine, University of North Carolina at Chapel Hill.

Dr. Sheps is a member of the Ad Hoc Advisory Committee on Public Health Service Hospitals.

STATEMENT OF DR. CECIL G. SHEPS, PROFESSOR OF SOCIAL MEDICINE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, AND MEMBER OF THE AD HOC ADVISORY COMMITTEE ON PUBLIC HEALTH SERVICE HOSPITALS

Mr. HUGHES. We have your statement, Dr. Sheps, which will be admitted as a part of our record, and you may proceed in any way you see fit.

Dr. SHEPS. Thank you.

I am grateful to you for this opportunity to testify at these hearings which are concerned with the present and future role of the U.S. Public Health Service Hospitals in the health care delivery system of our country. I had the opportunity to learn a lot about these hospitals through my membership on the Ad Hoc Advisory Committee on the Public Health Service Hospitals which was appointed by Secretary Califano in January 1978, and rendered its report last August 31.

My range of experience in the delivery of health services in the United States includes a few years in the private practice of medicine and 11 years as the director of two large general hospitals each of which was associated with a medical school. I am presently Professor of Social Medicine at the University of North Carolina at Chapel Hill.

A major thrust in the field of social medicine is to learn how to understand, delineate in detail, and arrange to meet the medical needs of society with maximum effectiveness and efficiency. Thus, my major ongoing interest in my professional work has been to deal with the problems and methods of bringing the necessary full range of health care services to the public with special attention to the particular needs of certain segments of the population which have special and unique needs.

Through the work of the committee, I have been able to develop a good appreciation of the achievement of the Public Health Service Hospitals thus far and their present potential in carrying out their responsibilities. I was in full and enthusiastic agreement with all the recommendations that our committee made.

As you know, the committee report arrived at the judgment that, though there were some areas where improvement should be made, this country's commitment to American seamen is being carried out well by the Public Health Service Hospitals and that it is also true of the needs of the secondary beneficiaries, such as Department of Defense related persons and others. The committee, therefore, felt that these programs should be strengthened because it was not aware of any convincing evidence that providing this kind of service by purchasing it in the so-called open medical market in these communities would provide better or more economical service. In addition, the committee felt that the special health needs of the primary and secondary beneficiaries require careful and consistent attention and a direct and ready response on the part of those providing the care, and that this could be provided more reliably through having specified agencies and institutions undertake this responsibility formally and on a continuing basis. It was this reasoning that lead the committee to the conclusion that these institutions should remain in place and that they needed strengthening in terms of the nature of their health care mandate. Also, in some instances, certain additional resources are needed. Our recommendation for the closure of the inpatient facilities for acute general hospital care in Boston did not contravene the above-mentioned posture, but was made simply because the volume of use in that city is so severely limited as to make the continued use of the facilities for this purpose undersirable from the point of view of the cost and the quality of care.

You will recall that one of the recommendations that we felt was among the most important was to urge the redefinition of the mission of these institutions so that they should become regional centers for health care under the aegis of the Public Health Service—a recommendation that we made in order to improve the scope and effectiveness of the service programs offered by these institutions to their beneficiaires. This would also make it possible for the Public Health Service to develop programs which would demonstrate and test improved methods of providing medical care to populations. In this way, it seemed to us that the Public Health Service would not only improve its services to its statutory beneficiaries, but could develop a set of yardsticks which would be of great value as national decisions are made regarding medical care which is simultaneously effective, acceptable, and economical.

There is, at present, no generally accepted single best way to provide primary care. Therefore, these hospital centers should be stimulated to be flexible and innovative as they develop those service programs.

The special attention we gave to the identification and the development of the concept of primary care in these institutions represents, in the view of the committee, an extremely important supporting step which would provide the comprehensiveness and continuity of responsibility which is so crucial to a program of effective and economical medical care. Furthermore, when these institutions develop as regional centers and free themselves from the restricted narrow inpatient context of general hospitals, those institutions which already have an established tertiary care capacity which is operating at a high level of quality in a cost-effective manner, should not be dismantled. In those hospitals which do have this capacity, a regional approach should be taken and arrangements made for the use of such facilities and services in other institutions in the community as part of the comprehensive program centered in the regional health center operated by the Public Health Service. There was some discussion earlier today which indicated that some people appear to have misinterpreted the ad hoc committee's recommendation in this regard. The committee did not recommend the dismantling of tertiary care. It did recommend that where this could not be provided on the basis of standard quality, scope, and size, on the basis that we identified, then it should be arranged for in other ways.

I've not had the opportunity to be close enough to the developments since the committee report was rendered and since the hearings that your committee held on this subject last September to be certain of all the developments that have taken place. However, I was, of course, pleased, as I'm sure were other members of the ad hoc committee, with the statement that Secretary Califano made to your committee on September 28 of last year indicating his support of our major recommendations and his instructions to Assistant Secretary Julius Richmond to undertake certain measures of implementation.

You will further recall that the committee recommended that more flexibility should be given in the administration of these programs at each site and that attention be given to the serious constraint of the personnel ceilings by number which restricts the ability of some of these institutions to provide the care that is needed. It is my understanding that this has not yet been done. This is a repressive constraint which I hope will be removed soon. It can be done by not increasing the total expenditures by a single dollar.

It is my understanding that no action has as yet been taken to meet the capital needs which were recommended by our committee for some of the institutions. These represent either the pressing need to upgrade facilities to meet basic life safety codes or to provide adequate facilities for primary care activities that are now being conducted by these institutions. I hope that this compelling matter will get the attention it deserves without any further delays. Otherwise, the patients being served by these institutions continue to be at substantial, and in my view, inexcusable risk.

I should like now to say a few words about our recommendation No. 5, that "The PHS Hospitals and Clinics should relate closely to community needs and the planning efforts of local health systems agencies." It is my understanding that a good bit of activity has taken place in this regard. The committee believed that this would to be a very important step. It was aware of the fact that, in this process, there would be a good deal of negotiation and a great need for improving community understanding of the fact that the PHS Hospitals have a special role which often goes beyond serving the local community and that they must direct their attention primarily to meeting the health needs of their primary beneficiaries and the needs of the poor, specifically, community residents with unmet medical care needs. The committee specifically had in mind "underserved populations" as defined in the various Health Service Administration programs.

It was, of course, to be expected that, in the current competition for patients amongst hospitals which are currently concerned about maintaining their occupancy levels, there would be invidious comparisons made between the public and the private sector. I would simply say that there are two issues involved here which need to be understood, both of which are crucial to the effective future development of health services in this country. One is that all people including the poor, should be able to choose their source of care, and the second is that the committee was deeply convinced, as I mentioned earlier in this testimony, of the need for a Federal health care activity which could provide a yardstick for use as Federal financing of the services provided by the private sector proceeds in the future. Developing the appropriate appreciation of the validity of this approach and the importance of these two principles takes time, and it is important that the Public Health Service Hospitals, both in terms of their overall direction in Washington and in the communities they serve, to be able to speak clearly and convincingly about their mission.

I know something, Mr. Chairman, of the deep interest in, and dedication to, the mission of the Public Health Service Hospitals that has been characteristic of your committee over the years. Your continued understanding and support for the future development of these institutions and their programs is crucial.

I thank you, Mr. Chairman, for giving me this opportunity to discuss these institutions and their programs with you. And I would be glad to respond to any questions that you may have.

Mr. Lowry [presiding]. Thank you for an excellent statement, Dr. Sheps.

We have a vote on the floor which is going to occur in about 12 minutes. I would like to request that you wait until we come back from that vote for questioning, if you would be so kind.

We have a Member of Congress here, Mr. Baltasar Corrada. If you would like to give your testimony now, before we go over to vote, that might work out timewise. We certainly appreciate your taking the time to come here.

STATEMENT OF HON. BALTASAR CORRADA, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PUERTO RICO

Mr. Corrada. Thank you, Mr. Chairman.

I have written testimony, which I will offer for the record, and ask that it be included in the record in its entirety.

I just would like to commend the committee for these hearings, and to state that in my district, in San Juan, Puerto Rico, we have an excellent Public Health Service health clinic, which is of vital importance to us.

As you know, Puerto Rico is a very important area in terms of the American Merchant Marine. We share about 30 percent of the entire market of the goods that are shipped through American vessels, and through that Public Health Service Clinic we take care of American merchant seamen, fishermen of different nationalities, and other people.

I would just like to express that the continuation, the maintenance of this kind of health facility, we view it as essential for the merchant marine, in the American Merchant Marine serving Puerto Rico.

Mr. Lowry [presiding]. Mr. Corrada, thank you very much for coming and testifying on this subject that is important for all of us, and particularly the district that you represent.

Your testimony will, of course, be a part of the entire record, and we appreciate your being here.

Mr. Corrada. Thank you very much, Mr. Chairman.

[The following was received for the record:]

PREPARED STATEMENT OF HON. BALTASAR CORRADA, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PUERTO RICO

Mr. Chairman and distinguished members of this committee, I am pleased to speak before you today about a matter that deserves the utmost attention of all of us, that is, the importance of the Public Health Service Clinic in San Juan, Puerto Rico.

Now that we are discovering ways in which the best health care can be provided to merchant seamen at sea as well as on shore, I am taking this opportunity to speak on behalf of the Clinic in San Juan and its importance in providing medical services to the merchant seamen.

This Clinic is the only one of its kind in the Island. It serves American merchant seamen, foreign merchant seamen, fishermen of different nationalities, United States Coast Guard personnel, Federal uniformed personnel temporarily stationed near the San Juan Metropolitan Area, Federal service personnel and Department of Defense retired personnel.

It also acts under a contract with the local government in providing medical services to local prisoners.

It serves also as physical examination center for civilians recruited by the Federal Government.

This facility is designed to provide primary and ambulatory services and as such does not provide medical services which requires overnight stay of patients. Patients with more serious ailments are transferred to other Hospitals in the area.

Services in this facility include minor surgery, dental clinic, laboratory tests, physiotherapy, radiology, and others. The clinic serves approximately 2,000 people per month and has a staff of four doctors and other para-medical personnel making a total of 25 persons.

I strongly support any effort to maintain facilities of this kind.

Mr. LOWRY. We will recess. We have an amendment on the nuclear—a type of moratorium on the nuclear. We will recess until 5 minutes after 4.

[Short recess.]

The CHAIRMAN [presiding]. The committee will come to order.

Thank you, Dr. Sheps. We have been experiencing a series of votes on this energy appropriation. It is going to take an hour off during the day.

At this time I will yield to counsel for questions for the record.

Mr. SEIFERT. Was it the intent of the Ad Hoc Advisory Committee, Dr. Sheps, to have its recommendations considered as a whole, or were they separable in any way?

Dr. SHEPS. I think that they all sort of hang together. I think most of them are mutually supportive. For example, the notion that the PHS Hospitals are doing a good job and need to be strengthened in some respects, is related in the mind of the committee, to the recommendations about improving physical facilities, and about the primary care emphasis. We did not see the latter as being separate and distinct, but rather supportive.

Mr. SEIFERT. Was there any discussion during the proceedings of the committee that would lead you to believe that it was the intent of the Ad Hoc Committee to reshape the hospitals so that they looked like something other than what they are now? Did you really want to make them community hospitals?

Dr. SHEPS. It depends on what you mean by that expression, community hospitals. We were always clear about the fact that those hospitals had an overriding obligation to their primary beneficiaries and, close behind that, to their secondary beneficiaries.

Mr. SEIFERT. You heard testimony this morning, Dr. Sheps, that HEW was delaying their work on these hospitals, pending result of the recommendations of the HSA's.

Now, the HSA's, we would assume, would base their recommendations on the needs of the community. How did you contemplate that kind of planning process becoming involved in the way you thought that PHS hospitals should be structured?

Dr. SHEPS. You raise an important point, and the committee was aware of that, at least in general terms. It was always conscious of the need which I tried to refer to in my prepared testimony, for the development of an appropriate community understanding of the fact, that regardless of the individual community per se, the Public

Health Service hospitals had an overriding obligation that went well beyond the community. On the other hand, it did seem reasonable to us that the resources and the ability to serve that was available in the Public Health Service Hospitals, should be made available to certain needy portions of the community, when this could be done without deprecating their primary responsibility. That was our notion.

Mr. SEIFERT. Do you have any idea of your own, or based upon your own information or upon deliberations of the Ad Hoc Committee, of how much jurisdiction the HSA's should have over this particular delivery system?

Dr. SHEPS. That is a very difficult question to answer in what might resemble quantitative terms. I would say that it appears to me that the Public Health Service has statutory responsibilities that were given to it by Congress, and if there would appear to be a conflict between that kind of responsibility and the statutory responsibility given by Congress to the HSA's, then that would have to be faced openly and resolved.

We saw the need to work with HSA's as being related to the fact that these Federal resources are seen as being in the community and therefore they ought to be put to optimum use. At the same time, as it would provide a better opportunity than existed before, for the individual Public Health Service Hospital, when it had the need for highly specialized services that are needed rarely, to work out those arrangements with other hospitals in that community. So it was really a two-way street.

Mr. SEIFERT. On page 4 of the general recommendations of the Ad Hoc Committee, there is a conclusion that provision of care by PHS is less costly than would be the purchase of care in the private sector.

Then you go on to distinguish between efficiency and utilization. Could you explain the difference, and how that relates to cost?

Dr. SHEPS. Yes, I think so. What is involved here is the committee's view that if you have a full-time salaried staff of a certain size representing a certain cluster of services, and it is fully utilized, that clearly would be less expensive than buying those items of service on the so-called open medical market. On the other hand, if you have a cluster of services, and a certain staff that is not fully utilized, then that service becomes more expensive. That is the compelling reason for moving toward full utilization.

Mr. SEIFERT. All right.

We will ask this one question, and then we are going to have to recess for another vote.

In all instances, I gather from the report, you found the PHS system being able to deliver care more reasonably than would be available in the private sector, utilization aside?

Dr. SHEPS. I would have to answer with a qualified yes, qualified in the sense that we were not in a position to do a very careful accounting type of evaluations.

Mr. SEIFERT. Is this attributable to the system, or just to the service population?

Would tertiary care delivered by the PHS system be cheaper than in the private sector?

Dr. SHEPS. Yes, if the services were fully utilized.

Mr. **Seifert**. Is there a fear in the private sector of the invidious comparison?

Dr. **Sheps**. I am not so sure it is a fear of invidious comparison, as much as wanting to stay in business as long and as rigorously as possible. That is the kind of confrontation involved here.

The **Chairman**. We will recess for just a few minutes.

[Short recess.]

The **Chairman**. The committee will come to order.

Mr. Seifert?

Mr. **Seifert**. Dr. Sheps, if you will continue with the answer you were in the middle of when we recessed.

Dr. **Sheps**. There is one additional reason that seemed to us to be really quite sensible as the committee was developing this recommendation. Given the fact that throughout the United States from now on, no institution can enlarge its program unless the HSA is involved and approves it and, given the fact that there is an attempt to integrate all these developments and to balance them, it seemed to us it would really be an unfortunate situation which would do the Public Health Service and the merchant seamen's program a disservice if this one institution were seen to be sticking out by itself and saying "We are not interested in what you heard or want, we are going to do what we want to do, and we are not even interested in talking with you about it."

That is not the same as being governed by the HSA in all respects. We said that they should work with the HSA's.

Mr. **Seifert**. You were here when I read from this radio statement by an HSA official in San Francisco. The last thing he said was that, they cannot be equal and unique at the same time.

Do you agree with that conclusion?

Dr. **Sheps**. No, I do not. Not at all.

Mr. **Seifert**. So they can have a unique Federal purpose, or broad purpose, which is outside the community?

Dr. **Sheps**. Yes, and there is a good precedent for this, counsel. That precedent is the teaching hospitals that are operated by, or closely in relation to medical school. In such instances this type of case is always made and generally accepted.

Mr. **Seifert**. What is, generally, the relationship between running the tertiary care programs and providing primary care?

Dr. **Sheps**. I am glad you asked that question because that is often not understood as well as it should be. There are two primary reasons why the committee came down so strongly on the strengthening of primary care in the PHS Hospitals. One was that a very significant portion of the effectiveness of tertiary care depends on what happens afterwards. In fact sometimes the need for it is often determined by what happens before. That is why, in my testimony, I used the word supporting, because it can make a tremendous difference in the ultimate results, in the lives of patients, if the total program is working well. The second reason is that the absence of primary care is where most of the anticipatory and follow-up preventive aspects of medical care falls down in the United States, and this is also true of beneficiaries. We felt that for both reasons the total program would be stronger if primary care was strengthened in the PHS Hospitals..

Mr. **Seifert**. I know we are being a bit repetitive now, but I think it is an important issue.

The purpose in recommending an emphasis on primary care was not to eliminate tertiary care, but in fact to reinforce it?

Dr. **Sheps**. And to make it more effective, to make its results lasting, that is right. At the same time, however, in the interest of completeness, I need to add that we did feel that it would not be wise of public health care hospitals to continue to provide tertiary service where the demand was not great enough for them to maintain an operation that was neither economical nor of adequate quality. The Staten Island Hospital has a whole series of services that are of high standard, and that are used quite a bit. Certainly these ought to be maintained at strength.

The **Chairman**. The situation then develops in an area, as it has in Staten Island where we have added substantial new hospital construction in the last 4 or 5 years.

Now that that construction is in place, it appears to be slightly underutilized because of the phase-in period. The new 450-bed hospital is presently staffed at about 315, and at that level will be fully staffed up to the 450-bed level in about a year or two. We now have some people in the medical community making the statements and assertions that Public Health Service is now intruding in that Staten Island Hospital care area, even though it never had the area for it.

Dr. **Sheps**. I would expect that.

The **Chairman**. I would say there is a jealousy of the Public Health Hospital, of its standards and staff, and of its ability to serve at a substantially lower cost than the private nonprofit hospital. We are getting into exactly the types of conflicts here that we are trying to avoid.

Dr. **Sheps**. I understand that, sir. However, I think that that kind of interaction or discussion is unavoidable. If the Public Health Hospital does not participate in HSA discussions, you would still have that view expressed, and the tone would be worse. If it does, at least there is an open discussion, and that is why I think, despite the problems, this is a sound thing to do. However, one's position should be very clear. As I said in my testimony, I think it is very important for Public Health Service in Washington, and in these hospitals, to be clear and explicit about this kind of thing, of the invidious comparisons that are made, when people say: "There are too many beds." So, let's close the public institution. Why pick on the public institution? I knew where a young female assistant professor married a full professor. This bringing them under the purview of the nepotism policy and they suggested that she resign. They did not suggest that he should resign.

The **Chairman**. They should suggest that he resign.

Dr. **Sheps**. I would point out that almost all new construction in the private sector these days is based on 90-, 95-percent loans, and there is a very high interest rate. I know one institution where the retirement of that debt alone starts that institution's per diem cost rate at $85. So that when invidious comparisons are made, it is important to recognize that the capital investment that has been made in Public Health Service Hospitals does not carry that implication.

The CHAIRMAN. Now, I would like to give you another example of how this is starting to work, HEW should be well aware of it and I have every intention, through these hearings, of making them aware of it. The new voluntary hospital in Staten Island comes on line although the local HSA is supposed to prevent duplication of services. When the question comes up regarding the placement of the C.A.T scanner, it goes in the Staten Island Hospital, and not the Public Health Hospital even though the Public Health Hospital is larger and has a larger staff. The handwriting is almost on the wall that that is going to be the result that HSA's are going to take, because of this, let us say, almost compliant role that HEW has dictated to the Public Health Hospitals.

Dr. SHEPS. I would think, sir, that there is another factor, that is that the HSA's are local, and though there is a limit of 49 percent of membership representing the providers, they are nevertheless very strong, and oftentimes the consumer representatives are somewhat intimidated by the mystique of medicine, and all that. So—it is going to take time, and lots of open discussion, before there is the kind of public understanding that is needed to developed that, even when they make their resources available to the general community, so that the general community understands that these institutions have an overriding responsibility to certain major beneficiaries.

The CHAIRMAN. In spite of the fact that the other hospitals in the community wanted cachment areas they insisted that the Public Health Hospital have no cachment?

Dr. SHEPS. I would only say, sir, that this is something that one hopes will change, and I think it is more likely to change if there is open discussion and interaction than if there is not.

The CHAIRMAN. Mr. Seifert?

Mr. SEIFERT. Doctor Sheps, when considering the needs of the medically underserved, what consideration was given the medical needs of the merchant seaman?

Did you ever look at merchant seamen as a medically underserved group?

Dr. SHEPS. We had data presented to us by various groups, including the unions, telling us about that. It seemed to us that the level of service problem of the merchant seamen had to do largely with accessibility to the service. For the other underserved groups that are in the other categories which the Health Service Administration has—it is very often a question of inability to pay more than it is access.

Mr. SEIFERT. And when you looked at the PHS system, did you consider what role it played, or could play, or should play in regard to the health of seamen while at sea, away from the institution?

Dr. SHEPS. No, I am afraid we did not. The reason for that, sir, is that our task was to look at the hospitals alone. Although, having read some of the testimony that is going to be given at these hearings I would agree that it would not have hurt us to spend a little time on that.

Mr. SEIFERT. We hope that these hearings will fill the void.

Dr. SHEPS. Yes.

Mr. SEIFERT. A void you admit was not filled, although it should have been.

Based upon what you know, and what you have observed, would it be as easy for a community hospital, for the voluntary sector, to provide outreach services, the type that we are going to be talking about tomorrow, on a par with that which could be provided for by the PHS?

Dr. SHEPS. I do not believe so, and I would like to tell you the reason. It is for the same reason that we think where you have a significant number of beneficiaries of this special type, that they need to have an agency that is directed to do that. This has to do with understanding one's population, understanding one's patients, in terms of where they come from, how they spend their days, what their problems are, both from the point of view of occupational risk of various kinds, and their general social status.

This is not strictly a matter of tender loving care. This is really a matter of understanding your patients. If there is one persistent complaint that the American public has with the practice of medicine, it is that it seems to be cold. Not dealing with human beings.

One of the things that impressed us tremendously, as we went around to these hospitals, is the degree to which that staff was attuned to its major beneficiaries, understood them, and spoke their language. That is one of the reasons why, for example, we—one of our recommendations was to strengthen further the work of the advisory committees that represent that constituency.

It is for that reason, because if someone else did it, it would be the reasoning once in a while, somebody needs something, and it would not have—you could not rely upon it quite as much for these various emergency requests, and so on, to add up to a picture which would be given consideration in advance, and not simply at the time of the problem.

So I am very clear about the difference, sir.

Mr. SEIFERT. Thank you.

The CHAIRMAN. Thank you, Doctor Sheps, we really appreciate your contribution.

Dr. SHEPS. Thank you.

The CHAIRMAN. The next witness is Mr. Charles Mollard, Vice President, Seafarers International Union.

Chuck, we are sorry to hold you up, but we had to do a water resources bill, and an energy bill.

STATEMENT OF CHARLES MOLLARD, VICE PRESIDENT, SEAFARERS INTERNATIONAL UNION OF NORTH AMERICA, AFL-CIO

Mr. MOLLARD. Those are certainly important bills.

My name is Charles Mollard, Vice President of the Seafarers International Union of North America, AFL-CIO.

The Seafarers International Union of North America, AFL-CIO, appreciates this opportunity to testify regarding the U.S. Public Health Service Hospital System and the health care of U.S. maritime workers.

At the outset, we wish to reaffirm our support for the Public Health Service system of hospitals, clinics, and staff. Our members continue to rely on it, for the majority of their health care. They have found the PHS system remains the best suited for the special needs of U.S. maritime workers in terms of prompt and priority health care of all types.

We are pleased, that after so many years of struggling to avoid the closing of the Public Health Service system, we can now turn to the more constructive issue of health care and the health needs of U.S. maritime workers. This committee's strong support of the system is one of the reasons that we can look to more positive aspects of PHS care.

The SIU has been part of a number of groups meeting under the PHS's Seamen's Health Improvement Program, SHIP, established by PHS last year. In the process, we have had the opportunity to make many constructive proposals to the Public Health Service regarding medical service for marine workers.

Among them have been proposals for a toll free number for seamen to call for information on the PHS system and to request the use of emergency medical services; efforts to revamp the system of priority care to assure seamen the continued fast turnaround in receiving medical care that they need to sail on modern U.S. vessels; and an effort to better respond to the changing needs of PHS patients in the inland waters and the offshore industries in the gulf.

All of these initiatives have been met with excellent cooperation and support by the PHS administration and staff. They have acted to implement many of these proposals and we believe the effort will pay off in higher utilization in rates by marine workers in PHS facilities.

One of the key issues discussed at the various SHIP conferences is health aboard ship. It seems that while the medical care available to the average U.S. citizen has improved dramatically over the years, care at sea has remained stable or even declined insofar as professional training is concerned.

Seamen are one of the few American workers who have no doctor available in the workplace for days or weeks at a time. A serious accident onboard can be aggravated by the lack of care and/or continued exposure to the stress of work.

Despite the lengthy periods they are at sea, U.S.-flag merchant vessels are not required to carry a crewmember with advanced medical training. The medicines available aboard U.S. ships remains widely divergent, depending on the shipowner and the pattern of usage of the materials.

Clearly, what is needed is a requirement that every U.S.-flag vessel carry a crewmember with advanced medical skills, on the level of an ambulance paramedic, who can give medical treatment at sea. This person must be backed up by a well-equipped ship's medicine chest. Since the Public Health Service has no control over these areas, only congressional intervention with the appropriate agencies can produce the needed early changes in this situation.

In addition, improvements are needed in the satellite system to link ships to shore facilities. Every U.S. ship must be able to communicate with the satellite. The PHS land station must have on hand the records of the patient being discussed, as well as a range of staff.

If a Public Health Service doctor could then talk directly to the medically trained member of the crew as the patient is examined, there would be a greater chance of providing remedial care.

For an effective system of marine medical care to be set in place, we believe the following steps are needed:

One, a member of the vessel crew must have advanced medical training through approved courses of study.

Two, an upgraded ship's medicine chest with a proper supply of medicines and equipment must be maintained and monitored by Federal agencies.

Three, the ship-to-shore radio satellite system involving the PHS must be improved so that the shipboard medical person can talk directly to shore-based PHS physicians about the patient. This communication system would also assist in better care in the event a seaman is hospitalized overseas.

Four, a central PHS communication station must be set up and be manned around the clock to serve this program. It could be set up at a major PHS Hospital, and use existing staff. A photostat of all health records of American mariners should be on hand at this station.

This comprehensive marine health system could lead to earlier care on a regular basis for American workers at sea and contribute to an increase in the recovery rate from both severe and light injury. This system would produce a direct savings for the U.S. fleet in man-days lost due to illness and the cost of repatriating men home.

Since a member of the existing crew of U.S. vessels could undergo the extra medical training, the program would not necessitate a further manpower burden for U.S. vessel operations. The feasibility of such an approach was proven in earlier limited health service training programs for members of U.S. vessel crews.

A medical service training program for selected members of the crew should be run under the direction of the Public Health Service. Speaking for the seafarers, we are willing to provide our members with whatever training is needed in advance health care education to meet PHS training requirements.

The SHIP groups have also had to face the problem of occupational illness and injuries aboard ship. It is our belief that many of these occupational problems can be traced to the failure of the U.S. Coast Guard to apply reasonable occupational safety and health standards to the U.S. Merchant Marine.

We have constantly pointed up the effect of noise, heat, and excessive overtime on the health and safe working conditions of our crews. Despite this effort, the American-flag merchant vessel is one of the last remaining areas of U.S. commerce that has no meaningful occupational safety and health rules.

When marine employees are worked too long or too hard, when they suffer from isolation and fatigue, all of these things can contribute to illness and injury. Yet, the Coast Guard continues to only talk about the problem.

One of the most positive steps the committee could make would be to require the Coast Guard to promulgate basic safety and health laws for U.S. seamen and enforce them with the help of the Public Health Service.

An example of these rules would be limits on noise aboard U.S. vessels or on the maximum safe work periods for certain duties.

American seamen deserve to have the same quality health care and safety in their workplace as other American workers. By additional regulations to upgrade marine medical care and occupational and health rules, this goal can be attained.

We again wish to express our appreciation to the committee for their continued support and interest in the PHS system and the health needs of U.S. marine workers. We believe that the work of the PHS SHIP groups is one of the most important aspects of the PHS program, and must be continued.

We hope that the committee will support our recommendations for improved health care aboard U.S.-flag vessels at sea.

The CHAIRMAN. Thank you, Mr. Mollard. We had a very effective program at the Public Health Hospital in Staten Island, called the Physician's Assistants' Program.

Would you tell us what effect you thought that program had on health care to the American Merchant Marine?

Mr. MOLLARD. We feel that that was an excellent program. The type of course that was given in that program was, and is very similar to the type of paramedic course that we are recommending in our statement.

However, due to the change in the manning scales aboard U.S.-flag vessels, there has been a decrease in the carriage of the purser-pharmacist mates, as the graduates of that program are called. The resultant care aboard ship has not been of any advantage to the seamen aboard, since these trained crewmembers are not carried aboard the average American vessel.

The CHAIRMAN. Counsel?

Mr. SEIFERT. Mr. Mollard, given the short time that a seaman is in port, do you think that the system now is responding to them rapidly enough?

Mr. MOLLARD. I think, like any other system, there can be improvement. We have seen that through the meetings of the Patient Advisory Councils, that we have improved the response of the Public Health Service to the fast turnaround type of vessels that we have today.

One of our big issues at those meetings has been to give the seamen the proper priority for care, so that he can immediately be taken care of, and meet the vessel's schedule, when she is departing.

Mr. SEIFERT. I think we all agree that seamen's health has to be provided for. Let us shift to something a little more mundane.

You said, "this system would produce a direct savings for the U.S. fleet in man-days lost due to illness, and the cost of repatriating men home."

Can you just discuss this with us a little? Do you know the cost of repatriation, the cost of replacement, the cost of overtime work assumed by those who filled the berths of those who are disabled while at sea?

Mr. MOLLARD. I really would not have any dollar figures.

Mr. SEIFERT. Could you get any?

Mr. MOLLARD. I think we could, through our contacted operators, probably provide some figures for the record.

[The following was received for the record:]

THE SEAFARERS INTERNATIONAL UNION
OF NORTH AMERICA, AFL-CIO,
Washington, D.C., August 20, 1979.

Hon. JOHN M. MURPHY,
Chairman, Committee on Merchant Marine and Fisheries, House of Representatives,
Room 1334, Longworth House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is the data promised to the Committee on June 18, 1979, during the hearings on the Public Health Service Hospitals and Clinics. The data seeks to quantify the cost to U.S.-flag liner shipping companies of repatriating and replacing seamen who become ill or who are lost at sea.

This data point up the costs incurred by the United States' Merchant Marine due to inadequate shipboard medical care. As we noted in our testimony, we believe the Coast Guard's poor record of promulgating occupational safety and health regulations in the maritime industry contributes directly to these costs.

The SIUNA regrets the delay in forwarding this requested information to the Committee. The cost data was provided to the SIUNA by numerous United States' flag shipping companies, and delays were experienced as this information had never before been compiled in a coordinated manner. We feel it is an important indication of the need for preventative action on the part of the Congress to:

1. Improve shipboard medical care through better medical training of certain shipboard personnel.
2. Establish an improved system of communication between ships at sea and the PHS.
3. Authorize a Committee request to the Coast Guard that it end its delays in promulgating occupational safety and health rules for United States' shipping.

If you have any questions regarding the enclosed information, please do not hesitate to contact me.

Sincerely,

CHARLES C. MOLLARD,
Vice President.

Enclosure.

AVERAGE ANNUAL COST DATA FOR U.S.-FLAG LINER SHIPPING COMPANIES

CARRIER NO. 1.—REPATRIATION OF ILL AND INJURED SEAMEN

	Transportation	Medical treatment	Total
Illness	$103,500	$82,500	$186,000
Injury	67,100	23,700	90,800
Total	170,600	106,200	276,800

Replacement of ill or injured seamen:

Transportation plus miscellaneous expenses

Illness	$90,000
Injury	60,000
Total	150,000

CARRIER NO. 2.—REPATRIATION AND REPLACEMENT OF ILL AND INJURED SEAMEN

U.S. Gulf-Europe trades: Average voyage costs—$7,700.
U.S. Atlantic and Gulf-Far East trades: Average voyage costs—$5,800.
U.S. Gulf-Europe trades: Average voyage costs—$4,100.
All routes: Average yearly costs total—$384,000.

Mr. SEIFERT. What happens when a seaman is out at sea, and he suffers an attack of acute appendicitis?

Mr. MOLLARD. What happens depends on where the vessel is located. The vessel may divert course and go to the nearest port of call, which obviously could have a steaming time of anywhere from several days to a week. In cases where they are near some shoreside stations, depending on the configuration of the ship, it may be feasible to lift the seaman off by helicopter evacuation. It really depends on the need.

There is nothing approaching what we have, if we are working shoreside, where we can have an ambulance pick somebody up, and take them immediately to the hospital. For the seaman this delay obviously results in much more serious consequences.

Mr. SEIFERT. The kind of training that you recommend in your testimony, for a person aboard ship to provide health care, what would be the difference?

Mr. MOLLARD. As we would see the difference, obviously this type person is not a doctor, but we would have someone who would have some basic understanding of first-aid and health care. With the satellite communications system, it would be hoped that that person could communicate, through the satellite, to a Public Health Service facility, such as the one in Staten Island, and get the proper advice of how to treat the patient immediately.

Mr. SEIFERT. Have these discussions been part of your deliberations in the SHIP program?

Mr. MOLLARD. Yes, in the the SHIP program there have been discussions of this type of program, and the SHIP group is working in this area.

Mr. SEIFERT. I have no further questions, Mr. Chairman.

The CHAIRMAN. Chuck, we certainly appreciate your contribution today.

We will have another full day of hearings starting tomorrow at 10 o'clock, and the committee will stand adjourned.

Mr. MOLLARD. We appreciate this committee's commitment to the Public Health Service Hospital program, and the health care for seamen.

Thank you.

The CHAIRMAN. All right, thank you.

[The following information was received for the record:]

PREPARED STATEMENT OF VICE ADM. PAUL E. TRIMBLE, USCG (RET.), PRESIDENT, LAKE CARRIERS' ASSOCIATION

Mr. Chairman and members of the committee, I am Paul E. Trimble, President of Lake Carriers' Association, representing domestic bulk shipping on the lakes. Though we are not appearing at these hearings, we do appreciate the opportunity to participate because of the importance to our vessel personnel.

Our members operate 131 bulk vessels and carry well over 100 million tons of raw materials annually. The cargoes include ore and limestone for the steel making industry; coal for power generation; farmers' grain to export points or processors' docks; petroleum products for power generation, domestic heating and distribution terminals; and cement, sand and gravel for the construction industry.

Regular ports of call include small and large lake ports at the source of the materials or transfer point and thence to unloading facilities. Shipping between these scattered points proceeds round-the-clock, including loading and unloading.

Though USPHS does not operate hospitals in the Great Lakes, it does have four outpatient clinics at the major ports, it does have numerous contract hospitals and contract physicians throughout the lakes to provide medical service at the widespread ports of call. I am attaching a list of the 1978 facilities for the Committee's convenience.

With these arrangements emergencies can be handled expeditiously through the prearranged and published listings. There is no question of where there is medical capability, no question of credit, and willingness to serve round-the-clock, on weekends or holidays. Not only is the seaman better taken care of but there are less delays for the vessel.

It is also helpful to have radio access to reliable medical advice to assist a Master in determining whether to evacuate a medical case or proceed to the next port.

As to general health problems of seamen, we do have a recommendation looking towards the welfare of seamen, their shipmates' safety and the responsibilities of vessel operators. There should be physical standards for entry ratings. If there are disqualifying physical defects for the physical requirements for skilled ratings, the unskilled will not waste time for unreachable advancement, as well as possibly making the vessel unseaworthy. Having an unskilled on board who is physically unqualified for advancement also works to the detriment of the owner.

I do appreciate the opportunity to comment on this important subject to Great Lakes seamen and vessel operators.

Attachment.

U.S. PUBLIC HEALTH SERVICE FACILITIES

Great Lakes Ports
1978

(Issued by Lake Carriers Association)

This list of U. S. Public Health Service Facilities is issued for use aboard Lake Carriers' Association member vessels.

Masters referring men to Public Health Service facilities should observe the following instructions, as set forth in the U. S. Department of Health, Education and Welfare, Public Health Service booklet "MEDICAL CARE FOR SEAMEN," HEW(HSA)- 76-2016.

Seamen Eligible for Medical Care

THOSE:

(1) ***Employed on board*** **vessels of the United States, registered, enrolled, and licensed under United States Maritime Laws, except canal boats engaged in the coasting trade, and whose duties primarily involve the care, preservation or navigation of such vessels . . .**

How Is Eligibility Established?

When applying for care at any Public Health Service facility a seaman must present a properly executed Master's Certificate of Service, a continuous discharge book, certificate of discharge or other evidence that he has been employed as a seaman. ***THIS IS IMPORTANT.*** **Admission to PHS Hospitals and Outpatient Clinics is accomplished faster if proper papers are available . . .**

A seaman who is able to write will be expected to sign his name on the face of the Master's Certificate before the certificate is signed by the Master of the vessel. The seaman will also be expected to verify his signature when presenting the certificate at a Public Health Service facility . . .

What About Emergency Care?

The public Health Service will assume the cost of emergency medical care obtained from other than PHS Hospitals, Outpatient Clinics or Contract Physicians ONLY under the following circumstances:

(a) When a seaman is too ill or badly injured to travel to a Public Health Service facility, the seaman or someone acting in his behalf must request authorization from the Director of the nearest PHS Hospital, Outpatient Clinic or from a Contract Physician. When the Director or Contract Physician is satisfied that the seaman is eligible and his condition is a true emergency, he will grant authority for the requested care.

(b) Request for authorization must be made immediately when the seaman seeks treatment. *THIS IS IMPORTANT*. Use of telephone or telegraph facilities provides early consideration of the request. *NO CONSIDERATION WILL BE GIVEN TO REQUESTS RECEIVED AFTER DISCHARGE FROM THE HOSPITAL.*

It should be understood that any authorization given will be conditioned upon the establishment of the seaman's eligibility through proper documentation of sea service or illness/injury while employed aboard a documented vessel. IF ELIGIBILITY IS NOT ESTABLISHED THE PHS WILL NOT ASSUME RESPONSIBILITY FOR THE COST OF THE CARE.

Contract Physicians

Many Public Health Service facilities have contracted with private physicians in order that these physicians may provide necessary medical care to eligible Public Health Service beneficiaries. These Contract Physicians are generally located in geographic areas where there are no PHS medical facilities.

If you require medical care and there is no PHS Hospital or Outpatient Clinic nearby, you should check the local telephone directory under "U. S. Government, Department of Health, Education, and Welfare" to determine whether a local physician may be listed as a Public Health Service Contract Physician. In addition, you may call or write to the nearest PHS facility to inquire whether there is a Contract Physician convenient to you.

CONTRACT PHYSICIAN'S OFFICES

City and Contract Physician	Address	Telephone
ILLINOIS		
JOLIET 60431	57 W. Jefferson St.,	
Gregory M. Carey, M.D.	Suite 500	(815) 727-7421
INDIANA		
EVANSVILLE 44715		
Joseph C. McCarthy, M.D.	518 South Green River Rd.	(812) 423-6871
HAMMOND 46323		
John Ye Kun Song, M.D.	6429 Kennedy Ave.	(219) 844-1030
MICHIGAN CITY 46360		
Medical Group of Mich. City, Inc.	1225 E. Cool Spring Ave.	(219) 879-6531
MICHIGAN		
ALPENA 49707		
James Greenwood, M.D.	115 North First Ave.	(517) 354-8444
BAY CITY 48706		
Donald B. Garvin, M.D.	1420 Center Ave.	(517) 894-2741
CHARLEVOIX 49720		
Robert G. Martin, M.D.	707 Bridge St.	(616) 547-6469
CHEBOYGAN 49721		
Nicholas Lentini, M.D.	401 Elm St.	(616) 627-5657
ESCANABA 49829		
William A. Lemire, M.D.	104 Doctors Park	(906) 786-1244
FRANKFORT 49635		
Gordon Willoughby, M.D.	104 Fifth St.	(616) 357-3521
Fred R. Thacker, M.D.	104 Fourth St.	(616) 352-2431
GRAND HAVEN 49417		
Peter A. McArthur, M.D.		
Grand Haven Medical Center	1310 Wisconsin St.	(616) 842-7150
HOUGHTON (HANCOCK) 49930		
Paul G. Goodreau, M.D.	1111 Helca St.	(906) 482-1893
HARBOR BEACH 48441		
Charles W. Oakes, M.D.	8970 Sand Beach Rd.	(517) 479-4453
HOLLAND 49423		
Eli A. Coates, M.D.	120 Waukazoo Dr.	(616) 396-8119
W. LUDINGTON 49431		
William S. Martin, M.D.	107 Ludington Ave.	(616) 843-9774
Robert E. Ewing, M.D.	603 E. Tinkham Ave.	(616) 843-3220
MANISTIQUE 49854		
Manistique Medical Center		
Duane L. Waters, M.D.	115 North Lake St.	(906) 341-2153
MARQUETTE 49855		
Larry E. Braak and	1414 W. Fair	(906) 288-7711
Barbara E. Lyons, M.D.'s	Marquette Medical Center	

MICHIGAN (Continued)

City and Contract Physician	Address	Telephone
MENOMINEE 49858		
Herman R. Burkardt, M.D.	534 First St.	(916) 863-5944
MUNISING 49862		
Con Fahrbach, M.D.	Medical Center, Sand Point Rd.	(906) 387-2149
MUSKEGON 49442		
Robert D. Risk, M.D.	1160 Ransom St.	(616) 722-6384
PORT HURON 48060		
Claud A. Ludwig, M.D.	916 7th St.	(313) 982-5700
ROGERS CITY 49779		
Robert C. Ries, M.D.	573 North Bradley Hwy.	(517) 734-2171
ST. IGNACE 49781		
F. Howard Hague, M.D.	Mackinac Straits Hospital 220 Burdette St.	(906) 643-8474
SAULT STE. MARIE 47783		
Earl S. Rhind, M.D.	300-306 Court St.	(906) 632-2251
TAWAS CITY 48763		
Norman Payea, M.D.	217 Newman St.	(517) 362-2141
TRAVERSE CITY 49684		
William D. Peterson, M.D.	876 West Front St.	(616) 946-4851
MINNESOTA		
DULUTH 55802		
Noel E. Tosseland, M.D.	729 Medical Arts Bldg.	(218) 727-2788
ST. PAUL 55106		
E. C. Emerson, M.D.	806 East 7th St.	(612) 725-4242
SILVER BAY 55614		
Donald D. Haase, M.D.	50 Outer Dr.	(218) 226-4461
Peter Y. Leonardson, M.D.	50 Outer Dr.	(218) 226-4461
Thomas M. Clifford, M.D.	50 Outer Dr.	(218) 226-4461
TWO HARBORS 55616		
Gerald E. Church, M.D.	Community Clinic Health Center	(218) 834-2171
David W. Armin, M.D.	19 - 16th St.	(218) 427-6692
NEW YORK		
OGDENSBURG 13669		
Arthur D. Redmond, M.D.	616 State St.	(315) 393-1971
Edward P. Whalen, M.D.	215 Rensselaer Ave.	(315) 393-4640
ROCHESTER 14609		
Charles A. Manuele, M.D.	627 North Goodman St.	(716) 232-7577
OHIO		
ASHTABULA 44004		
Richard S. Millberg, M.D.	430 West 25th St.	(216) 998-1212

OHIO (Continued)

City and Contract Physician	Address	Telephone
FAIRPORT 44077		
Benjamin Fisher, M.D.	421 High St.	(216) 357-5252
LORAIN 44052		
Tong W. Moon, M.D.	125 West 21st St.	(216) 245-5105
MARBLEHEAD 43440		
Jack C. Witker, M.D.	211 West Main St. or P. O. Box 302	(419) 787-4131
SANDUSKY 44870		
Russel E. Taylor, M.D.	334 E. Washington St.	(419) 625-9832
Henry G. Lehrer, M.D.	1015 West Washington St.	(419) 626-5612
TOLEDO 43611		
St. Vincent Emerg. Med. Services Frank E. Foss, M.D.	2213 Cherry St.	(419) 259-4204
Point Place Medical Clinic, Inc.	5119 Summit St.	(419) 726-3416
PENNSYLVANIA		
EASTON 18042		
E. Glen Elder, M.D.	1440 Washington St.	(215) 258-6151
WISCONSIN		
ASHLAND 54806		
John E. Kreher, M.D.	206 Sixth Ave. West	(715) 682-6622
A. A. Koeller, M.D.	206 Sixth Ave. West	(715) 682-6622
GREEN BAY 54303		
Dousman Clinic Donel Sullivan, M.D.	1745 Dousman St.	(414) 494-9661
Bertram I. Milson, M.D.	1745 Dousman St.	(414) 494-3411
KEWANNEE 54216		
Reynold M. Neseman, M.D.	213 Ellis St.	(414) 388-3211
MANITOWOC		
R. H. Strong, M.D.	821 Washington St.	(414) 682-7373
MILWAUKEE 53211		
North Point Medical Group, Ltd. D. Ovitt, M.D.	2388 North Lake Dr.	(414) 271-3700
Goldberg Medical Clinic	3531 Burleigh St.	(414) 871-5600
RACINE 53403		
Jose Reyes, M.D.	911 - 16th St.	(414) 637-5664
SHEBOYGAN 53081		
Robert A. Keller, M.D.	11011 North 8th Ave.	(414) 457-4461
STURGEON BAY 54235		
John J. Beck, M.D.	1715 Rhode Island St.	(414) 743-5521
Edward P. McAuliffee, M.D.	1717 Rhode Island St.	(414) 743-5521
SUPERIOR 54880		
Charles J. Picard, M.D.	425 - 21st Ave. East	(218) 398-6612
TWO RIVERS 54241		
Stephen L. Weld, M.D.	2219 Garfield	(414) 793-1181
WASHINGTON ISLAND 54246		
Paul E. Rutledge, M.D.		(414) 847-2424

CONTRACT HOSPITALS

MICHIGAN

ALPENA 49707
Alpena General Hospital
1501-1511 W. Chisholm St.

BAY CITY 48706
Bay Medical Center, Inc.
300 Mulholland

CHARLEVOIX 49720
Charlevoix Hospital
Lake Shore Drive

DETROIT 48226
Detroit-Macomb Hospital Association
690 Mullett

DETROIT 48201
Harper Hospital
3825 Bush St.

ESCANABA 49829
St. Francis Hospital
1018 South 13th St.

FRANKFORT 49685
Paul Oliver Memorial Hospital
224 Park Ave.

GRAND HAVEN 49417
North Ottawa Community Hospital
1309 Sheldon Rd.

LUDINGTON 49431
Memorial Hospital of Mason County
One Atkinson Dr.

MANISTEE 49660
West Shore Hospital
1465 E. Parkdale Ave.

MANISTIQUE 49854
Schoolcraft Memorial Hospital
Main St.

MARQUETTE 49855
Marquette General Hospital

MENOMINEE 49858
Menominee County Lloyd Hospital

MUSKEGON 49443
Hackley Hospital
1700 Clinton St.

PORT HURON 48060
Port Huron Hospital
1001 Kearney St.

ROGERS CITY 49779
Rogers City Hospital
555 North Bradley Highway

ST. IGNACE 49781
Mackinac Straits Hospital

SAULT STE. MARIE 49783
Chippewa County War Memorial Hospital
500 Osborn Blvd.

TAWAS CITY 48763
Tawas St. Joseph Hospital
N-55 and Court St.

MINNESOTA

TWO HARBORS 55616
Lakeview Memorial Hospital
11th Ave. and 4th St.

NEW YORK

OGDENSBURG 13669
A. Barton Hepburn Hospital
214 King St.

OHIO

ASHTABULA 44004
Ashtabula General Hospital
2420 Lake Ave.

CLEVELAND 44106
The Mount Sinai Hospital of Cleveland
University Circle

LORAIN 44052
St. Joseph Hospital
205 W. 20th St.

SANDUSKY 44870
Providence Hospital
1912 Hayes Ave.

WISCONSIN

ASHLAND 54806
Memorial Medical Center, Inc.
304 E. Front St., Rm. 7

GREEN BAY 54301
Bellin Memorial Hospital
744 South Webster
and
St. Mary's Medical Center
1726 Shawano Ave.

MILWAUKEE 53211
St. Mary's Hospital
2320 North Lake Dr.

SHEBOYGAN 53081
St. Nicholas Hospital
918 Huron Ave.

U.S. PUBLIC HEALTH SERVICE OUTPATIENT CLINICS

BUFFALO, NEW YORK 14203
50 High Street, Rm. 609
(716) 842-2017

CHICAGO, ILLINOIS 60605
1439 S. Michigan Ave.
(312) 353-5900

CLEVELAND, OHIO 44113
New Post Office Building
West 3rd St. and Prospect Ave.
(216) 522-4524

DETROIT, MICHIGAN 48215
14700 Riverside Dr.
(313) 822-9300 and 822-7715

Corrections and Additions

American Steamship Co.,
Buffalo, N.Y., May 31, 1979.

Hon. John H. Murphy,
Chairman, Committee on Merchant Marine and Fisheries, Room 1334, Longworth House Office Building, Washington, D.C.

Dear Mr. Chairman: This letter is written for your hearing to be held June 7th on: United States Public Health Service Hospitals and Clinics: Their mission, administration, and future role in health care delivery.

American Steamship Company has 18 ships operating on the Great Lakes and we employ approximately 600 seamen on these ships.

The role of the U.S. Public Health Service for the health of these Merchant Seamen has been one of the utmost value. The U.S. Public Health Service maintains a large number of facilities in the port cities of the Great Lakes. Were it not for these facilities, many of our seamen would be unable to obtain proper prompt medical treatment. This is because many Great Lakes ports are in remote locations. To obtain the services of private physicians would be extremely difficult whereas a U.S. Public Health Service physician is on call 24 hours a day for emergency service.

Our company has long recognized the excellence of the care given by the U.S. Public Health Service. We support maintaining the service at its present level and feel that any lessening of the present care would have a severely deleterious effect upon the health and welfare of our seamen.

In the interests of all our seamen, I urge you to support the U.S. Public Health Service so that it can continue to provide them necessary medical care and treatment.

Sincerely,

Louis E. Ervin,
Vice President, Marine Personnel.

[Whereupon, at 5:03 p.m., the committee adjourned, to reconvene at 10 a.m., Tuesday, June 19, 1979.]

UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

TUESDAY, JUNE 19, 1979

HOUSE OF REPRESENTATIVES,
COMMITTEE ON MERCHANT MARINE AND FISHERIES,
Washington, D.C.

The committee met, pursuant to notice, at 10:08 a.m., in room 1334, Longworth House Office Building, Hon. Mike Lowry, presiding.

Present: Representatives Murphy, Lowry, Donnelly, de la Garza and AuCoin.

Staff present: Carl Perian, Gerald Seifert, John Bruce, Paris S. Russell, and Liz Coker.

Mr. LOWRY. The Committee on Merchant Marine and Fisheries will come to order.

Chairman Murphy is working on the Panama Canal legislation at this time. As a matter of fact, I just left the committee a moment ago, so I have the privilege of sitting in on his behalf. I would like to read the opening statement of Chairman Murphy for this morning.

STATEMENT OF HON. JOHN M. MURPHY, CHAIRMAN, MERCHANT MARINE AND FISHERIES COMMITTEE

Good morning. We continue our oversight hearings on the health of U.S. Merchant Seamen, the institutions created to provide care, and the initiatives which are being or should be undertaken to protect the interests of our merchant seamen and to strengthen our merchant marine.

Yesterday, we examined the Public Health Service Hospital and Clinic System, an oversight we have undertaken many times in the past and one on which we will continue to concentrate. The PHS system since 1798 has been the cornerstone of the Nation's obligation to the U.S. Merchant Seamen, and it should continue to occupy the central role in any modern, coordinated health care delivery system in which the Federal Government has the major interest.

Today, it is our intent to explore further the standards for health on the high seas, the availability and use of innovative techniques in delivering health care and the effect of seamen's health on the economic health of the United States Merchant Marine and our U.S. fishing industry."

Our first witness today is Doctor James H. Erickson, Director, Bureau of Medical Service, Department of Health, Education, and Welfare.

Welcome to the committee, Doctor Erickson.

STATEMENT OF DR. JAMES H. ERICKSON, ASSISTANT SURGEON GENERAL, DIRECTOR OF BUREAU OF MEDICAL SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. ERNEST HARDAWAY, CHIEF, POLICY DIVISION; DR. TRUMAN L. McCASLAND, DIRECTOR OF PROGRAM DEVELOPMENT; AND RICHARD ASHBAUGH, DEPUTY DIRECTOR OF HOSPITALS AND CLINICS

Dr. Erickson. Thank you, Mr. Chairman. I first of all would like to introduce my colleagues who are with me at the witness table this morning. On my far left, Dr. Ernest Hardaway, who is Chief of our Policy Coordination Branch in the Bureau; Dr. McCasland, Director of the Office of Program Development within the Bureau; and to my right, Mr. Richard Ashbaugh, the Deputy Director of the Division of Hospitals and Clinics.

I am here today to discuss the health care of American seamen ashore and aboard ship. The traditional term "seaman" will be used in our discussion, although we recognize that women are also serving in various maritime occupations.

Since last August we have been reviewing the ways in which the Public Health Service delivers health care services to American seamen. We have met to discuss the matter with representatives of other organizations who share responsibility for, and an interest in, the health and safety of American seamen. These organizations include maritime industry representatives, seaman's unions, the Coast Guard, the Maritime Administration, and the National Oceanic and Atmospheric Administration.

This effort to improve the delivery of health care services to American seamen has been named the Seamen's Health Improvement Program (SHIP). Interested individuals and groups have been asked to meet periodically in small work groups to exchange ideas, analyze pertinent issues more extensively, and recommend alternative approaches to health care for this special occupational group of Americans.

Four specific areas which have been identified for closer examination are:

One, physical qualifications of American seamen;

Two, access to care;

Three, medical care at sea; and

Four, safety aboard ship.

We hope that SHIP will stimulate communication, interaction, and dissemination of information among those agencies responsible for the health and safety of American seamen.

The present revitalization of the maritime industry can be chiefly attributed to the Merchant Marine Act of 1970. In the past decade, vessels have become larger, cargo content and handling have changed, crews have become smaller, though usually more skilled, and time in port has been reduced drastically. We are concerned that our practices and procedures may not have kept up with the highly technological environment in which seamen work.

The maritime industry is unique in that in few other instances are the life and safety of all concerned so dependent upon the satisfactory performance of personnel, equipment, and vessel. The differences between the maritime industry and other industries are probably more pronounced, with respect to the workplace and the conditions under which people work, than is generally realized.

Some concern surrounds the issue of medical standards for American seamen. In the past, answers may have been elusive because responsibilities for seamen are scattered among agencies. For example, the U.S. Coast Guard is responsible for assuring the seaworthiness of vessels and the licensing of personnel. The Coast Guard carries out its responsibilities in this regard in a number of ways, principally through inspections and credentialling procedures. Maritime jobs are classified and labeled by occupational rating. Traditionally, however, the Coast Guard has looked to the Public Health Service for assuring the seaworthiness of seamen. The SHIP program has facilitated better communications between agencies in this regard.

Some potential beneficiaries do not know they are eligible for PHS care because of the lack of publicity and inconsistent understanding of the term "seaman." Lack of knowledge by those concerned with the working and living conditions of seamen can cause inaccurate health care assumptions, and less than adequate instruction regarding follow-up care. In some cases, extended voyages, fatigue, boredom, inadequate medical supplies and equipment, and lack of trained medical personnel aboard ship can increase the likelihood of illness and injury.

The nature of the maritime industry makes for a mobile employee population which increases the difficulty of tracking patients and following their medical histories. It also limits the seaman's access to health education data, which is important in total recovery from illness and injury, and in the management of chronic diseases.

The onboard maritime environment is characterized by limited space, narrow passageways, steep staircases, unstable platforms, loud and repeated noises, and frequent, sometimes radical, changes in temperatures. The foregoing may be further complicated by situations in which work must be performed while everything—floors, walls, equipment, other workers—is wet and oily. In addition, there is the ever present danger of accidental death and injury, peer pressure to skillfully handle every eventuality, and limited recreational opportunities.

Due to improved technology and rising operational costs, crew size has been steadily reduced, usually with no reserve staff assigned on voyages. Therefore, if, due to illness or injury, a seaman cannot perform the duties as assigned, other seamen have to work extended periods. The role of fatigue on crew illness and injury needs to be studied more extensively to determine more precisely its effect on accidents or malfunctions of equipment and vessels.

I support SHIP enthusiastically and consider it one of the most important programs under our Bureau's direction. I have heard a great deal about the enthusiasm with which SHIP has been received and the generous spirit with which experienced and knowledgeable people have joined this cooperative effort.

Let me also point out that we have recently published a new addition of the "Ship's Medicine Chest and Medical Aid at Sea." This book has been the mainstay of medical care aboard merchant ships which do not have a physician aboard.

In addition to chapters on the diagnosis and care of injuries and illnesses, it contains a listing of recommended medications, medical equipment, and supplies which should be available aboard ships, depending upon the size of the crew and the distance from medical assistance ashore. The book emphasizes the critical need for prior training and continuing education for those members of the crew responsible for the delivery of emergency care, especially certification in cardiopulmonary resuscitation and the ability to accurately establish symptoms and transmit them via radio communication to medical backup ashore.

Major chapters of the book include: Emergency Treatment of Injuries, Treatment of Diseases, Care of Castaways, Cardiopulmonary Resuscitation, monographs which explain the use and cautions of the medications on board, the procedures for communicating with foreign medical resources, and Coast Guard procedures for helicopter evacuation at sea. Prior editions of the book have been used as a text at the U.S. Merchant Marine Academy, State Merchant Marine Academies, and by private boatowners and backwoodsmen.

We have been fortunate to have received excellent reviews of this publication and it is currently being utilized by various organizations and individuals on land as well as aboard river, lake, and seagoing vessels.

It is also necessary to improve the content of communications between ship and shore, and improve the mechanisms by which these communications are accomplished. When American flag ships at sea need medical advice, most often that advice is sought from a PHS hospital or clinic.

With current communications equipment, there are some delays in the exchange necessary to provide medical advice and guidance. For instance, we have been told that it can take up to 3 hours to get a question from a vessel to a PHS facility, and another 3 hours to get a response back to the vessel.

We have had some initial discussions with staff of the Maritime Administration regarding the potential medical use of a satellite communications system, and that system is expected to be operational sometime in the 1980's. In our opinion, the capability to respond to MEDICO calls via satellite should be an integral part of that development. In order for the Public Health Service to be a more active participant in such an endeavor, we will collaborate with the Maritime Administration.

Thank you for the opportunity to share these comments with you. My colleagues and I will be pleased to answer any questions you may have.

Mr. LOWRY. Thank you, Doctor, for that statement.

Yesterday we discussed and listened to the expanded roles of the Public Health Service Hospitals working in the community, providing underserved areas with better care. Will that expanded role in any way reduce the top priority for the seamen in the care they receive on shore?

Dr. ERICKSON. No, it should not.

Mr. LOWRY. What are the safeguards we have against that occurring, just as a natural result of the community action that we saw ongoing with this new proposed program?

Dr. **Erickson**. The answer is, Mr. Chairman, we certainly realize we have legal and moral obligations to the American seamen, and they are indeed the primary beneficiaries, and it is incumbent upon us to see that that happens.

Certainly in our dealings with the HSA's and others with whom we deal. we will have to remind them and ourselves of that, and I think the SHIP program is one of the reminders that we have worked on among ourselves and with others.

Mr. **Lowry**. We have a profile of this past, of the merchant marine path?

Dr. **Erickson**. I am not quite sure what you mean by the profile.

Mr. **Lowry**. Well, it is a unique—in your testimony, you talk about it as a unique group to which you administer health care. I was just wondering what type of profile, for us to understand, that fits in.

Dr. **Erickson**. Well, certainly, for one thing, we have been made aware that the seaman population as a whole, is growing older, and therefore we are coming to be more cognizant of those diseases that affect the older age population, over 45, over 50, such as cardiovascular diseases, and so on. So I think that that is one aspect of the profile. We do not, at this time, have a complete breakdown, although we do have some recent information that shows illnesses and injuries sustained by percentage, by various American seamen. We can have some of those provided for the record if you would like.

Mr. **Lowry**. What kind of job are we doing in making seamen aware of their rights and benefits of the Health Service? You know, we hear a lot about this. It was discussed yesterday, what sort of procedure do we go through to do that? How do we really identify this group, to get that group up to receive benefits?

Dr. **Erickson**. For one thing, we are working right now on the republication of the little booklet, "Medical Care for American Seamen," which we will see gets disseminated to various unions, maritime groups, so forth. There have been meetings locally between hospitals and clinic staffs, and they are maritime union staffs, and so on, so through these various mechanisms of public relations programs, if you will, we hope to disseminate this information in a better way.

Mr. **Lowry**. One more question. Yesterday and today, the problems of communication, the SHIP, PHS Hospitals, seems to be a serious concern. Do we have dollar estimates of what type of equipment improvements are necessary to shorten that length of time in the communication base?

Dr. **Erickson**. Not to my knowledge, Mr. Chairman.

Mr. **Lowry**. As I understood from your statement, you are looking at a satellite program, but I do not know anything about that.

Dr. **Erickson**. I do not know much about it either, Mr. Chairman, but you know, without being an electronics engineer, it is my understanding that such a system could shorten it, and if it is going to be operational for a whole host of variabilities, one of the reasons that we would support that would be that we could see that we could link in and thereby shorten the ship-to-shore communications time.

Mr. **Lowry**. I believe this committee would be very interested in seeing more work done on that question, and more information developed, because I think we would share that concern in trying to improve that communication, if you could do it.

[The following was received for the record:]

Department of Health, Education, and Welfare,
Health Services Administration,
Rockville, Md., September 10, 1979.

Hon. John M. Murphy,
Chairman, Committee on Merchant Marine and Fisheries,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: Thank you for your letter of July 24 to Dr. James Erickson requesting information concerning our testimony before the Committee on Merchant Marine and Fisheries on June 18 and 19, 1979.

Your first question, regarding the utilization of the Seattle Public Health Service Hospital, has been answered in the insert to the hearing transcript which was returned to the Committee in early August.

I do have some additional information on the satellite communications program beyond that presented in testimony by Dr. William B. Walsh, Mr. Edward J. Martin, and Mr. Marvin Pitkin. The technical feasibility of a medical communications program using satellite transmissions has been demonstrated by the HOPE experiments, although a number of problems persist, including the cost of equipment required to implement the system aboard ships, the training of shipboard personnel to effectively use the advice obtained, and proper coordination with the various agencies involved. We have recently surveyed the existing state of communications within the PHS system and find great variance in the number of calls received as well as the response time. Both this issue and the training of shipboard staff are being addressed through the Seafarers' Health Improvement Program (SHIP). We recognize that communications now are frequently delayed between ships and our hospitals and see the technology that is promised by this work as a potential solution to the problem. Members of the SHIP staff met with MarAd representatives on May 5, 1979, to discuss satellite communications, and other meetings are being planned.

Sincerely yours,

George I. Lythcott, M.D.,
Assistant Surgeon General, Administrator.

Dr. **Erickson**. Yes, sir.

Mr. **Lowry**. Chairman Murphy?

The **Chairman**. I will defer to counsel. He has some questions.

Mr. **Seifert**. Thank you, Mr. Chairman.

Good morning, Dr. Erickson.

I would like to continue some of the questions which Mr. Lowry was pursuing with you, and see if we can thrash them out a little bit more.

On the way the public relations effort of the PHS system makes known to eligible beneficiaries the availability of the services. Do you have any idea of how large the group is that is not now being reached?

Dr. **Erickson**. That is a difficult question to answer, Mr. Seifert, because I think the problem lies in that we do not know where all of them are. It does pose some problems.

One thing we hope the SHIP program will do is, through the interchange with other agencies, that may have better information of where they are, they can help us to find out better.

Mr. **Seifert**. Is NMFS a group represented in the discussion of the SHIP program?

Dr. **Erickson**. The term NMFS?

Mr. **Seifert**. NMFS. I agree, let us quit dealing in acronyms. This is the agency with the Department of Commerce that has the responsibility for the fisheries program?

Dr. **Erickson**. Yes.

Mr. **Seifert**. So through the Sea Grant program, you could make some contact with that fishing population?

Dr. **Erickson**. Yes, sir.

Mr. **Seifert**. And that will be undertaken, I assume, as part of your PR effort?

Dr. **Erickson**. Yes, it is in progress.

Mr. **Seifert**. I would assume the first thing you would want to do in the designing of your PR program, is who they are, and where they are. I have not heard that from you, nor have I seen it in the progress from the SHIP program meetings. I would assume that one of your first priority items is to determine exactly who this population is, and where they are located. Otherwise there is no way that you can get it. I mean you are talking among yourselves.

Dr. **Erickson**. That is true, except that we hope that the other groups that are involved in this program will enable us to find out more about where these seamen are.

We are also working on a toll free number, an 800 number, which would allow them, wherever they are, to get to us more easily and more frequently.

Mr. **Seifert**. You say that—on page 2 of your testimony, you say, "we hope that SHIP will stimulate communication, interaction, and dissemination of information among those agencies responsible for the health and safety of American seamen."

How do you view the present responsibilities among the various agencies of Government. Is it useful, should it be a coordinating effort, do you view your role as that of a coordinator?

Dr. **Erickson**. Certainly I view that our role is involved in coordination. We have been in the SHIP program, a coordinator to date, and because we feel we are basically responsible for the health care of merchant seamen, and therefore we began to take this responsibility among ourselves to contact the various groups that are involved. I think it would be fair to say that no one group has the lead necessarily for the whole thing. There are different aspects of this, and you need the different agencies very definitely to share their own particular expertise in areas where they have that, but we are seeing a greater amount of coordination and interaction through the various task groups, and I think that that is a solid beginning. It is not completed, by any means.

Mr. **Seifert**. When Mr. Lowry asked you about the profile of the population you are serving, you seemed to equivocate on what the profile is, or whether there is one. Yet, further on in your testimony, on page 4, you indicate that fatigue is a major factor. You have seemed to identify at least one element in the profile of the merchant seamen upon which you are concentrating; that would presume some knowledge of the total need, or am I missing something here?

Dr. **Erickson**. We have been made aware, for example, that voyages have sometimes become longer with shorter turn around in port, and with containerized shipping, so the groups that we are dealing with have informed us that fatigue could be one factor. If you look at that, that would be one thing that would come to mind as a potential factor.

Mr. SEIFERT. Do you have a study underway, or are you planning one, which will identify the medical profile of the population group that you are supposed to be serving?

Dr. ERICKSON. Yes, we are hoping to do that in a much better fashion. I think we are beginning to get some information, but it is sketchy at this point in time. One of our hopes in this regard, is about our 6-month-old relationship with Johns Hopkins University in the occupational health area, and this will help us in the area of occupational health areas and profiles of seamen.

Mr. SEIFERT. You are referring to the testimony of Dr. Green, who will be wrapping up our hearing today?

Dr. ERICKSON. Yes.

Mr. SEIFERT. You indicate that in order for the Public Health Service to be a more active participant, you are talking about ship-to-shore satellite communication. You will collaborate with the Maritime Administration in regard to satellites expected to be operational sometime in the 1980's. You have played no role, however, in the design of that system?

Dr. ERICKSON. No, we have not, Mr. Seifert. We have staff-to-staff initial discussions, but we have not played a role in the design of that system.

Mr. SEIFERT. In the contract let by the Maritime Administration to explore the feasibility of this work, your agency played no role even though it was a major health care institution that did the actual study on the contract with MarAd: North Shore Hospital in Long Island. I think it is a Cornell University Teaching Hospital that was the institution at which this experiment was undertaken but, to the best of your knowledge, the Public Health Service did not participate?

Dr. ERICKSON. To the best of my knowledge, that is correct.

Mr. SEIFERT. Do you view that as good, bad or indifferent?

Dr. ERICKSON. Well, I am glad we are working with them now, and I think that is important to keep that collaboration going.

Mr. SEIFERT. The Ship's Medicine Chest, a copy of which is on the table is good. You say there is a critical need for prior training and continuing education. At one time, PHS did sponsor a training program for paramedics. Are you pursuing that further? What is your view of the need for trained people to use the Ship's Medicine Chest effectively?

Dr. ERICKSON. Yes, the Public Health Service Hospital in Staten Island has had, for several years, a program which is still continuing the physician assistant program. We are planning to have refresher courses available for those responsible for care of merchant seamen.

It is my understanding that the first one of those will occur this fall.

Mr. SEIFERT. Generally, what kind of contracts are you letting to assist you in pursuing your responsibilities as you have outlined to us today?

Dr. ERICKSON. I am not aware that there are any specific contracts outside. The people in the SHIP program are working with our own Division of Emergency Medical Services on various modules that can be utilized at various levels for those who are responsible for care at sea. So we are working within our own shop as it were.

Mr. **Seifert**. Thank you, Dr. Erickson.

Mr. **Lowry**. I yield to the minority counsel.

Mr. **Bruce**. I do have one question and the second one would follow.

There has been some discussion called the need for an improved communication system, either by a satellite or improvement of the current means of communication.

Do you see the need for establishing a Public Health communications system with a data bank for seamen? This has been the thrust of some testimony that we have seen and statements that we have read.

Dr. **Erickson**. If I understand you correctly, you are asking whether or not we would have a centralized data bank which would contain profile of seamen and so forth?

Mr. **Bruce**. Associated with that a communication facility of some sort, either by a satellite that is developed or current system of communication.

Dr. **Erickson**. It is hard to answer that question directly, because of my not knowing enough about satellite communication systems, but we would hope that as we know more about seamen and their profiles, we might be able to have a seamen's registry, for example, which could develop into something such as this. We have, currently underway, in our Seattle Hospital, a Public Health automated information system which has now been extended to two other hospitals and this could possibly grow into that profile. I do not know whether it would be easier to have one central location or to deal with the hospitals that are closest to where the injured or ill seaman is.

Mr. **Bruce**. One associated question. One of the difficulties apparently is the time delay between the receipt of a call ashore, say by the Coast Guard and the time within which one can contact the Public Health Service.

Do you see any way of improving the communication to cut down on this time lag?

Dr. **Erickson**. I think that working with the Coast Guard, and others in the maritime industry, technological advances might enable us to do that. I do not have anything specific in that regard, however.

Mr. **Lowry**. The gentleman from Massachusetts.

Mr. **Donnelly**. I have no questions, Mr. Chairman.

Mr. **Lowry**. Are there any other questions for this panel?

If not, thank you very much, Dr. Erickson. We appreciate your time and your testimony.

[The following was received for the record:]

PROPOSED MEDICAL TRAINING REQUIREMENTS FOR U.S. MERCHANT VESSELS

The following is a list of proposed requirements for grades of training for medical care at sea.

It is recommended that a requirement be established necessitating medically trained personnel be aboard each merchant vessel before departing port.

The level of training needed will be determined by the nature of the voyage and distance from medical facilities.

Example—

Grade 1—Uninspected Commercial Vessels

Grade 2—Merchant Vessels—Coastal and Island
Grade 3—Merchant Vessels—Ocean Voyages
Grade 4—Large Passenger Vessels

REQUIREMENTS FOR GRADES 1 THROUGH 4, MEDICAL TRAINING ABOARD SHIPS

	Grade—			
	1	2	3	4
First aid	16	52	75	52
Anatomy and physiology	0	10	6	192
Patient care	0	4	10	624
Patient assessment	0	15	40	214
Surgical assessment	0	0	20	154
Dermatology	0	0	2	64
Ophthalmology	0	0	4	32
Ear, nose, throat	0	0	6	36
Dental emergency	0	0	6	48
Orthopedics	0	0	0	80
Anesthesiology	0	0	1	32
Psychiatry	0	0	8	12
Urology	0	0	0	68
Obstetrics and gynecology	0	0	4	12
Pharmacology	0	10	30	184
Clinical lab	0	0	1	134
Surgical techniques	0	0	12	120
Environmental health	0	0	4	118
Dangerous and toxic cargoes	0	0	8	40
Radio communications	0	3	1	3
Administration	1	1	4	4
Total	17	95	240	2,223

MEDICAL CARE AT SEA

GRADE I

- I. First Aid (16 hours)
    - A. Wounds and Bleeding
    - B. Shock
    - C. Artificial Respiration (Cardiopulmonary Resuscitation)
    - D. Poisoning
    - E. Burns
    - F. Heat and Cold Injuries
    - G. Head and Spine Injuries
    - H. Bites and Stings
    - I. Fractures and Immobilization
    - J. Heart Attack, Stroke, Simple Fainting, and Epilepsy
    - K. Foreign Bodies in Eye, Air Passage, Food Passages
    - L. Rescue and Transfer
    - M. Internal Injuries
- II. Administration (1 hour)
    - Log Books
    - Record Keeping

GRADE II

- I. First Aid
    - A. Introduction to Emergency Care Training (3 hours)
        - 1. EMT Functions
        - 2. Vital Signs
    - B. Airway Obstruction and Respiratory Arrest (3 hours)
    - C. Cardiac Arrest (3 hours)
    - D. Mechanical Aids to Breathing and Resuscitation (3 hours)
    - E. Bleeding, Shock, Airway Care (Pulmonary and Cardiopulmonary Resuscitation) (3 hours)

F. Wounds (3 hours)
G. Musculoskeletal Care and Fracture of Upper Extremities (3 hours)
H. Fractures of Pelvis, Hip and Lower Extremities (3 hours)
I. Injuries of Head, Face, Neck and Spine (3 hours)
J. Injuries to Eye, Chest, Abdomen and Genitalia (3 hours)
K. Medical Emergencies I (3 hours)
    1. Ingested and Inhaled Poisons
    2. Bites and Stings
    3. Heart Attack
    4. Stroke
    5. Dyspnea
L. Medical Emergencies II (3 hours)
    1. Diabetes
    2. Acute Abdomen
    3. Communicable Diseases
    4. Mental Disorders
    5. Alcohol and Drug Abuse
    6. Epilepsy
M. Emergency Childbirth (3 hours)
N. Environmental Emergencies (3 hours)
O. Lifting and Moving Patients (3 hours)
P. Extrication from Trauma Areas (3 hours)
II. Anatomy and Physiology (8 hours)
    A. Musculo-Skeletal
    B. Major Organs
    C. Functional Aspects of Major Systems
    D. Common Terms (Major areas of the body)
III. Patient Care (4 hours)
    A. General Nursing Care
    B. Maintenance
IV. Patient Assessment (15 hours)
    A. History
    B. Physical Exam
        1. Brief Overview
    C. Triage
    D. Assessment of Unconscious Patient
V. Pharmacology (10 hours)
    A. Procurement
    B. Storage
    C. Usage
    D. Dose
    E. Drug Reaction
        1. Anaphylaxsis
        2. Minor Reactions
    F. Drug Interaction
    G. Generic and Brand Names
        1. Most Common
    H. Administration of Drugs
VI. I.V. Therapy (2 hours)
VII. Radio Communication (1 hour)
    A. Medical Checkoff
    B. Proper Terminology
VIII. Administration (2 hours)
    A. Record Keeping
    B. Drug Control
    C. Report Filing

GRADE III

I. CPR/Respiratory Emergencies (16 hours)
    A. Cardio-Pulmonary Resuscitation
        1. Airway Management
        2. Breathing
            a. artificial resuscitation
        3. Circulation
            a. external cardiac compression
    B. Choking Emergencies
        1. Foreign Body Obstruction of Airway

C. Special Resuscitation Techniques
   1. Electric Shock
   2. Near Drowning
   3. Noxious Gases
D. Mechanical Aids to Breathing
   1. Oxygen Administration
   2. Bag Mask Ventilation

II. Wounds (6 hours)
   A. Classification
   B. Bleeding Control
   C. Application of Dressings and Bandages
   D. Control of Infection

III. Shock (3 hours)
   A. Prevention
   B. Causes and Types
   C. Signs and Symptoms
   D. Treatment

IV. Injuries to Musculo-Skeletal System (12 hours)
   A. Anatomy and Physiology
   B. Types of Injuries
   C. Signs and Symptoms
   D. Treatment
   E. Patient Care

V. Injuries to Skull and Spine (8 hours)
   A. Anatomy and Physiology
   B. Injuries to Spine
      1. Signs and Symptoms
      2. Complications
      3. Treatment
   C. Injuries to Skull and Brain
      1. Signs and Symptoms
      2. Complications
      3. Treatment
   D. Monitoring the Unconscious Patient

VI. Poisons (4 hours)
   A. Recognition of Toxic Substance
   B. Signs and Symptoms
   C. Treatment

VII. Burns (2 hours)
   A. Classification of Thermal Burns
   B. Treatment
   C. Respiratory Burns
   D. Electrical Burns
   E. Chemical Burns

VIII. Heat and Cold Exposure Emergencies (4 hours)
   A. Localized Cold Injuries
      1. Immersion foot
      2. Frostbite
   B. Accidental Hypothermia
      1. Signs and Symptoms
      2. Complications
      3. Treatment
   C. Heat Exposure
      1. Heat Exhaustion
      2. Heat Cramps
      3. Heat Stroke

IX. Medical Emergencies (20 hours)
   A. Cardiac Conditions
   B. Diabetes
   C. Dyspnea
   D. Strokes
   E. Seizures
   F. Unconscious States
   G. Stings and Bites
   H. Radiation Injuries
   I. Abnormal Behavior
   J. Communicable Diseases

X. General Anatomy and Physiology (6 hours)
   A. Organ Systems of the Body

B. Medical Terminology
XI. Patient Assessment (40 hours)
  A. History
  B. Vital Signs
  C. Physical Examination
  D. Triage
  E. Signs and Symptoms
  F. Emergency Medical Identification
XII. Patient Care (10 hours)
  A. Transportation
    1. Extrication from Trauma Site
    2. Proper Carries
    3. Litters (type)
  B. General Nursing Care
  C. Special Nursing Care
    1. Catheterization
    2. Enemas
  D. Maintenance
XIII. Surgical Assessment (20 hours)
  A. Head and Neck Wounds
  B. Chest Wounds
  C. Acute Abdomen
  D. Genito-Urinary
  E. Ano-Rectal
  F. Extremities
  G. Back Injuries
  H. Hernia
XIV. Dermatology (2 hours)
  A. Anatomy and Physiology
  B. Signs and Symptoms
  C. Treatment
XV. Ophthalmology (4 hours)
  A. Anatomy and Physiology
  B. Eye Injuries
    1. Signs and Symptoms
    2. Treatment
XVI. Ear, Nose, Throat (6 hours)
  A. Anatomy and Physiology
  B. Signs and Symptoms
  C. Treatment
XVII. Dental Emergencies (6 hours)
  A. Anatomy and Physiology
  B. Signs and Symptoms
  C. Treatment
XVIII. Psychiatry (8 hours)
  A. Alcoholism
    1. Signs and Symptoms
    2. Treatment
  B. Other Drugs of Abuse
    1. Signs and Symptoms
    2. Treatment
  C. Depression
    1. Signs and Symptoms
    2. Treatment
  D. Mental Disorders
    1. Signs and Symptoms
    2. Treatment
XIX. OB-GYN (2 hours)
  A. Anatomy and Physiology
  B. Childbirth
    1. Routine
    2. Abnormal
  C. Other Emergencies
    1. Trauma
XX. Pharmacology (30 hours)
  A. Generic and Brand Name
  B. Procurement
  C. Storage

D. Usage
E. Dose
F. Drug Reactions
  1. Anaphylaxis
  2. Minor Reactions
G. Drug Interaction
H. Administration

XXI. Clinical Lab (1 hour)
A. Urinalysis
B. Occult Blood

XXII. Surgery (12 hours)
A. Suturing
B. Alternate Methods
C. Incision and Drainage

XXIII. Anesthesiology (1 hour)
A. Local Administration

XXIV. Environmental Health (4 hours)
A. Lighting
B. Ventilation
C. Food Sanitation
D. Liquid Transport (water)
E. Waste Disposal
F. Inspection
G. Hygiene
H. Pest Control

XXV. Dangerous and Toxic Cargoes (8 hours)
A. Health Hazards
B. Medical Control
C. Treatment of Injuries

XXVI. Radio Communication (1 hour)
A. Radio Telephone Procedures
B. Medical Checkoff
C. Proper Terminology

XXVII. Administration (4 hours)
A. Record Keeping
B. Drug Control
C. Report Finding

GRADE IV

I. First Aid (52 hours)
II. Anatomy and Physiology (192 hours)
III. Patient Care (624 hours)
IV. Patient Assessment (214 hours)
V. Surgical Assessment (154 hours)
VI. Dermatology (64 hours)
VII. Ophthalmology (32 hours)
VIII. Ear, Nose, Throat (36 hours)
IX. Dental Emergency (48 hours)
X. Orthopedics (48 hours)
XI. Anesthesiology (32 hours)
XII. Psychiatry (12 hours)
XIII. Urology (68 hours)
XIV. Obstetrics and Gynecology (12 hours)
XV. Pharmacology (184 hours)
XVI. Clinical Lab (132 hours)
XVII. Surgical Techniques (120 hours)
XVIII. Environmental Health (118 hours)
XIX. Dangerous and Toxic Cargoes (40 hours)
XX. Radio Communications (3 hours)
XXI. Administration (4 hours)

Mr. Lowry. Our next panel will be headed by Admiral Bell. Director, Office of Merchant Marine Safety, U.S. Coast Guard.

STATEMENT OF REAR ADM. HENRY H. BELL, CHIEF, OFFICE OF MERCHANT MARINE SAFETY, U.S. COAST GUARD, ACCOMPANIED BY COMDR. ROBERT PARROW, U.S. COAST GUARD

Admiral BELL. Mr. Chairman and members of the committee, I am Rear Adm. Henry H. Bell, Chief of the Office of Merchant Marine Safety at Coast Guard Headquarters. Thank you for this opportunity to talk to you about the Coast Guard's efforts in improving health care on board U.S. commercial vessels and the development of physical standards for our merchant seamen.

The Coast Guard recognizes that personnel serving onboard many U.S. commercial vessels do not have ready access to adequate onboard medical care in an emergency. If a major illness or accident occurs within helicopter range, the patient can be evacuated or treated, but at great cost in terms of risk, time, and money. Beyond helicopter evacuation range, the patient may die through no fault of shipboard personnel but rather because of the lack of onboard medical expertise.

The Marine Index Bureau advises that in 1978, over 74 illnesses and injuries were reported for every 100 jobs on U.S. oceangoing vessels over 1,000 gross tons. Our casualty statistics at Coast Guard Headquarters indicate that during the 5-year period between July 1, 1972, and September 30, 1977, there were approximately 646 heart attack victims on board U.S.-flag vessels. Ninety three percent resulted in the death of the victim. This death rate is 25 percent higher than the national average with 89 percent of the deaths between the ages of 40 to 69. The high death rate is only partially explained by the 50-year average age of the U.S. merchant mariner.

Recognizing the importance of these statistics, the Coast Guard, in cooperation with the U.S. Public Health Service, and in consultation with management and labor, is modifying the existing health care system based upon a revised edition of "The Ship's Medicine Chest and Medical Aid at Sea." I believe that volume was referred to previously, Mr. Chairman, "The Ship's Medicine Chest and Medical Aid at Sea," which is published by the U.S. Public Health Service, is required on certain U.S. merchant vessels. The text emphasizes the critical need for prior training and continuing education for members of the crew who are responsible for rendering emergency care; especially certification in cardiopulmonary resuscitation and radio communication procedure for describing symptoms to shoreside medical facilities. In order to thoroughly qualify an individual to handle all areas addressed in this manual, as much as 2 years of formal training would be required. In light of this and the need to raise the existing level of qualifications of personnel responsible for health care, the Coast Guard is proposing four levels of qualifications to best meet training time constraints and still provide a minimum level of expertise. Level 1 is a basic first aid course similar to that presently required for licensed personnel. Level 2 will be for vessels operating on inland, coastwise and Great Lakes waters. Levels 3 and 4 are designed for inspected oceangoing vessels.

The text of "The Ship's Medicine Chest and Medical Aid at Sea" and each type of vessel's medical locker will be color-coded to the corresponding level of qualification. This system will simplify identification of medical equipment designed for use with the same color-coded portion of the text. Standardization of medical expertise is another advantage in that a shoreside doctor in radio communication will know the relative training of the health-care provider and the equipment on board. The maritime unions, Federal and State maritime academies and shipping companies have adequate ongoing medical training courses available. The Coast Guard requirements will serve to standardize the level of qualification required and provide schools with guidance on the subject matter as well as the minimum number of hours required to qualify at each level.

As health care qualification has international implications, the U.S. delegation to the IMCO Subcommittee on Standards of Training and Watchkeeping is preparing a proposal concerning medical qualifications for presentation to IMCO in July 1979. The subcommittee will consider this plan in developing an international standard of medical qualification.

With regard to individual physical standards, the Coast Guard is revising its system designed to screen personnel upon entry into the seagoing maritime industry for the purpose of insuring that they are physically qualified to serve in the intended capacity. I will briefly describe our efforts to date.

First, I must apologize, Mr. Chairman, we have used another acronym. The acronym SAILORS has been created which broadly defines the physical skill areas varying with the particular jobs on board a vessel. The rate or profiling system is basic and will provide uniform terminology for any examining physician to express medical findings objectively. The Coast Guard, as the final authority in determining fitness, will make a decision based on the physical rating skill factors for each particular job. A seaman who may not qualify for one job may still be able to serve in a less critical position. Present procedures for appeals, waivers, and borderline cases will be clarified. I think, sir, the acronym SAILOR is explained here on the chart and rather than try to go over and describe it, I think it is fairly self-evident.

[The following was received for the record:]

MERCHANT SEAMAN PROFILE MATCHING SYSTEM

The profiling system will correlate physical capacity with physical demands of various maritime occupations. The acronym "SAILORS" has been created to broadly define this matching system, i.e., matching the right person for the right job. Each letter represents one of seven factors to be considered in correlating people to occupations.

Merchant seaman profile matching men to jobs

S—Overall strength and stamina
A—Strength of arms, shoulders, neck
I—Incapacitating diseases or conditions which would preclude employment
L—Strength of legs, hips and back
O—Observational powers (vision)
R—Reception of sound (hearing)
S—Stability

Each of the above factors has been assigned degrees which reflect relative amounts of strength, vision, etc., which are required by the job and are present in the job candidate.

Admiral **BELL**. With regard to satellite communication, I am of the opinion that we must first concentrate our efforts on improving the medical qualification of seagoing health care personnel to meet the immediate problems so that in the long term, the necessary medical expertise will be in place to effectively use the equipment.

In summary, Mr. Chairman, we believe that the Coast Guard has a workable and potentially effective system to insure that our merchant seamen will receive adequate emergency health care on board ship and that physically limited personnel will be restricted to jobs so as not to endanger themselves, their shipmates, or their ships.

That concludes my prepared statement. I will be happy to answer any questions that you may have.

Mr. **Lowry**. Thank you, Admiral.

The death rate, of course, is very large. What is the timetable for implementing a program of the medical personnel to be on the different types of vessels? When are we going to have this in operation, looking at this type of a death rate? Obviously, we are very concerned with that.

Admiral **Bell**. Yes, sir. What I have described this morning is truthfully a draft. We started on this about last September and we are at a stage now where we think it is a viable workable scheme. It is going to require both regulatory changes and, depending on the extent to which this will be expanded, it may require some legislative authority. Staying with just the regulatory changes necessary, I would anticipate it would take 18 months to put this in effect. Now, that means the wide full-blown scope of both the entry physical exam requirement and the color coding of the medicine chest for those ships or vessels over which we currently have authority. This does not rely on the Coast Guard developing courses. It utilizes existing courses which industry, both management and labor have in place, and it utilizes the expertise that both the Public Health Service and the civilian community have available. So that portion of it is already in place. It is a question of our getting our bureaucracy in gear and making it work.

Mr. **Lowry**. So the physical examinations you perform at the Public Health Hospitals?

Admiral **Bell**. Yes, sir, the physical examinations, as you know, in the current regulations, they specify Public Health Service Hospital, but then they make an exemption where, due to a burden on the seaman, if he is not near a Public Health Service Hospital, there are provisions for using recognized private physicians. This system, we hope, through the acronym SAILORS, would give a private physician who is essentially unaware of the requirement of the seagoing career, the basic criteria we would need to mark the man on.

The difficulty we face now is that some of the physicians are good physicians but they do not understand the rigors of a seagoing career and we have difficulty with some of their physical exams.

Mr. **Lowry**. Does not the unique, utilized Public Health Service Hospital, within the regulations, examinations, preparations, again point to the need to reach the primary responsibility of the primary hospital with regard to the seamen?

As we look at these other responsibilities?

Admiral **Bell**. Yes, sir.

Mr. **Lowry**. Because it looks to me like this would be quite a workload that would be going on to our medical services system to make this work.

Admiral **Bell**. I am not sure of that, sir. The same physical is now being given, would have to be given to the gentlemen. What he writes down would be different, but it would be the same physical. We are not increasing the number or frequency at the moment without some legislative change in the statute. But if we stay with our current authority, we will still have the same number of physicals. It will be just a different way of marking him, and it would hopefully take out the guesswork. The physician would not be called on to make a judgment on the man's ability to perform in an area in which he may not have a large amount of knowledge.

This, as I think you probably heard already, is an industrial arena with some unique features because of its isolation, it is a 24-hour exposure. Even some industrialized physicians are not aware of what the rigors that seamen are going to face. Hopefully, this system would be more objective in that a rating system which we are talking about would come up with numbers and you could match numbers against the particular license or rating the man is applying for.

So I do not see a large increase in workload for the PHS.

Mr. **Lowry**. Chairman Murphy?

The **Chairman**. No questions.

Mr. **Lowry**. Mr. Donnelly.

Mr. **Donnelly**. I have no questions.

Mr. **Lowry**. Mr. Seifert.

Mr. **Seifert**. Admiral Bell, what are the international standards right now for seamen's health? What did IMCO—International Maritime Consultative Organization—require and how does it compare to what you are now setting forth as a requirement in the U.S. Merchant Marine?

Admiral **Bell**. There are not currently any international standards. There are good words like medically fit, things like that. The International Labor Organization—ILO—since about 1973 has been actively discussing enhanced medical care aboard vessels and enhanced medical standards. There have been some reasonable medical standards established in the North Sea area, mainly in regard to contagious diseases and a certificate of health fitness that they require of their masters or their mariners annually. The discussions coming up are a joint IMCO-ILO undertaking that addresses both of the areas we are addressing here, the physical standards for the merchant mariner and the type of medical care aboard ship.

I think that, as far as I know, the discussions that we had at IMCO; that what we are trying to do is provide some form of training at a graduated level aboard a vessel so a man will know how to administer certain things on advice via shore or radio or the ship's medicine book. We are not training at a full doctor level. We rely on physicians and the book itself, and I am talking now in the IMCO arena. We are at this point, sir, to answer your question, I think we are tracking just about equally what IMCO and ILO are doing as far as putting something in effect.

Mr. **Seifert**. Are you aware of the level of health care provided aboard vessels of some of our merchant marine competitors and how it compares by our standards?

Do the Russians, for instance, do the Japanese provide a level of health care aboard their vessels which is different than ours?

Admiral **Bell**. I really cannot say, sir, because the little bit of knowledge I have is that vessels that have been on extended deployment, some of the Japanese fish factories, have gone out for long extended periods of time. They usually do have medical personnel on board responsible for that ship, and all the little tenders the mother ship takes care of.

Some Russian ships I have visited, not passenger vessels, again on extended deployment, do have paramedical personnel on board. But I am not aware of how to address the question worldwide.

Mr. **Seifert**. I wonder if we could shift back to the chart showing the levels of requirement for various vessels. I think that would be useful to cover further on.

Grade 4 is just the way it is now pretty much. When you are talking about passenger vessels, you are required to have a doctor aboard?

Admiral **Bell**. Yes, sir. We do not have many of those left.

Mr. **Seifert**. We do not have many of those left so really that fourth grade is a hope for the future, for the development of passengers and liners.

Let us go back to grade 3 now.

We are talking about most of our 500 some vessels now on the high seas, is that correct?

Admiral **Bell**. Those ships between grade 2 and grade 3 of which you are talking about comprise most of our deep draft vessels. We have some that are coasting, which are relatively close to land, the ones that are running our coasts east and west. They are much more amenable to helicopter evacuation or diversion into our ports for medical aid.

The ships transiting the Pacific and Atlantic, are definitely out of any possibility of getting medical help.

Mr. **Seifert**. Let us stop at this point and talk about ships that are running coastwise and which you said are within helicopter range. It is my understanding that there have been several helicopter rescues or evacuations which have resulted in some loss to the Coast Guard in terms of manpower and equipment, is that right?

Admiral **Bell**. Yes. I am sorry. I was anticipating.

Mr. **Seifert**. How many were there and what percentage of the evacuations result in some kind of unanticipated cost to the Coast Guard?

Admiral **Bell**. Sir, if I could, I would prefer to provide that for the record. But could I make a comment on that?

[The following was received for the record:]

Department of Transportation,
U.S. Coast Guard,
Washington, D.C., September 20, 1979.

Hon. John M. Murphy,
Committee on Merchant Marine and Fisheries,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your letter of 27 July 1979 to Rear Admiral Henry Bell concerning his testimony before the Committee on Merchant Marine and Fisheries; Public Health Service Hospitals and Clinics.

The direct interaction between the Coast Guard and the United States Public Health Service (PHS) at the policy level, with respect to proposals put forth at IMCO concerning the International Labor Organization (ILO), medical evaluation and evacuation has been minimal. Our recommendations have been based primarily on input from our own staff of PHS commissioned officers on duty at Coast Guard Headquarters. It is through their expertise and wide experience in the fields of medical evaluation and evacuation at sea that out proposals have been based. The proposals, copies of which are enclosed, will be considered by IMCO during 1982.

Since November 1978 the Coast Guard has had representatives in attendance at almost all of the meetings sponsored by the U.S. Public Health Service, Division of Hospitals and Clinics (DHC) which consists of four working groups as follows:

I—Physical Qualifications for American Seamen
II—Access to Care
III—MEDICO/SAR/Care at Sea
IV—Safety Aboard Ship

In August 1979 a week long meeting was held by Work Group III discussing and recommending curricula for medical training and related subjects. It is through these meetings which are attended by representative of diverse maritime interests that we obtain the input from the Public Health Service which is eventually incorporated into our discussions and proposals at IMCO.

I hope this has been responsive to your inquiry.

Sincerely,

J. M. Fournier,
Captain, U.S. Coast Guard,
Chief, Congressional Affairs Staff.

Enclosures.

Preliminary Draft Resolution—Training and Qualifications of Persons in Charge of Medical Care Aboard Ship

The Assembly,

Noting Article 16(i) of the convention of the Inter-Governmental Maritime Consultative Organization concerning the functions of the Assembly,

Considering the serious dangers to human life and safety when sickness and accidents occur and are not properly treated owing to the limited medical training of personnel aboard ships at sea,

Noting further the existing internationally accepted instruments and publications which relate to medical training and, in particular, the Resolution by the Joint ILO/WHO Committee on the Health of Seafarers in 1973, the ILO/IMCO Document for Guidance, 1975 and the relevant provisions of the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978,

Recognizing that many ships which do not carry doctors are often in an isolated situation at sea where reliance must be placed upon the medical training of those on board,

Desiring to improve the level of safety in such ships by establishing a reasonable minimum standard of theoretical and practical medical training beyond first-aid level for persons placed in charge of medical care aboard ships at sea as part of their regular duties,

Having considered the Report of the Maritime Safety Committee on its forty-first session,

Recommends that:

(a) all ships engaged on voyages of more than 600 nautical miles in length during which the ship is more than 200 nautical miles from a place of safety which do not carry a doctor, should carry at least one person who has satisfactorily completed a course of more advanced training in medical care;

(b) the advanced medical training referred to in the paragraph above should be provided by a specified programme of appropriate content and number of hours in practical and theoretical medical training beyond the level of first-aid, Invites all Member Governments to implement as soon as practicable the provisions of the recommendations contained in this Resolution.

Medical Training—Proposed Text of Letter to ILO and WHO

SUBMITTED BY THE DRAFTING GROUP

1. IMCO has an obligation to give guidance to Administrations, shipowners and seafarers on matters concerning the safety of merchant ships and their crews. In this regard, it shares with ILO and WHO responsibility concerning training in medical care. The purpose of this letter is to endeavour to co-ordinate the efforts of all three organizations in evolving a common approach to training in this area.

2. In this, it would appear logical to base any such guidance on existing, internationally accepted instruments and publications. In particular, any training should be based on: (1) The Resolution adopted by the Joint ILO/WHO Committee on the Health of Seafarers on Medical and First Aid Training for Ship Personnel, 1973; (2) the Interrnational Medical Guide for Ships; (3) the Medical first Aid Guide for use in Accidents involving Dangerous Goods (MFAG); and (4) the Medical Section of the International Code of Signals.

3. These form the basis of the training guidance and requirements contained respectively in the Joint ILO/IMCO Document for Guidance 1975 and the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978 (STCW). IMCO considers it desirable that the next session of the Joint ILO/WHO Committee on the Health of Seafarers develop outline training syllabuses to carry out the purpose of these provisions. In establishing the content of courses, IMCO believes that account should be taken of the three stages of instruction envisaged in the 1973 Resolution, i.e.: Instruction on the immediate action that should be taken on encountering an accident or other medical emergency; Elementary training which will enable a crew member to take immediate effective action in the case of accidents or illnesses that are likely to occur on board ships (first aid); and more advanced medical training based on the International Medical Guide for Ships, similar national guides, and the other instruments and publications referred to above.

4. It is clearly essential that such syllabuses should reflect the most recent medical knowledge available. It is understood that the International Medical Guide and the MFAG are presently under revision. Such syllabuses can therefore be practicably developed only after the revised guides are available.

5. IMCO therefore urges the Joint ILO/WHO Committee on the health of Seafarers to develop at its next session the training syllabuses referred to and looks forward to participating in that work.

Admiral BELL. One of the problems we do have is that right now the level of training aboard those vessels you are addressing, the coasting vessels, is at grade 1 or below. The doctor at shore tries to communicate and he is talking medical terminology with someone on the ship who knows what the Band-Aid is and nothing more. The frustration, a lot of times, is that we feel the doctor is not able to communicate, not able to get what he considers adequate medical input to the conversation; therefore, he requests evacuation of the patient. One of the benefits that we see from this level of training is that the person onboard, who has gone through either the 95- or the 240-hour course, would understand the essential color code. The doctor would have an idea of the level of training he has had and the communication between them, we hope, will result in a lot fewer recommendations for evacuation and a lot better recommendations for onboard treatment.

[The following was received for the record:]

Losses Due to Helicopter Accidents

For the record, and in further response to your specific question, in the past year we have had two helicopter accidents which occurred during medical evacuations. One helicopter was a total loss amounting to about $1,670,000. The second helicopter was salvaged with repair costs estimated at $1,300,000. The cost of training the three Coast Guard crewmen who were killed in one of these accidents is estimated to be $422,000. The total unanticipated cost of the other evacuations during the past

12 month period was some $5,236,000. During this period, 528 medivacs were completed. Only the two accidents or 0.38 percent resulted in unanticipated cost to the Coast Guard. Those two losses, however, as you can see, represented about 65 percent of the other normal medivac operating expenses.

Mr. Seifert. I assume then that your experience shows that most of the evacuations could have been taken care of for these vessels with that level of training, the 95 hours?

Admiral Bell. Yes, sir, I think that is a fair statement.

Mr. Seifert. And the standard that you will be setting is based upon some experience factor which you have had in providing some level of care even if it is just transportation?

Admiral Bell. Yes, sir.

Mr. Seifert. To these people who are in need of assistance in the Coast Guard?

Admiral Bell. That, of course, does not say that the coasting trades people could not come up with things that could not be treated onboard. At least the shoreside personnel will have a better chance to evaluate the evacuation than we certainly do have nowadays.

Mr. Seifert. In making your recommendations to the ILO and IMCO, did the Public Health Service play any role or did you consult the Public Health Service in any way?

Admiral Bell. Yes, sir. As you know, we have Public Health physicians attached to our staff and we utilized their expertise. I personally cannot validate whether they talked to their compatriots in a different part of the Health Service.

Mr. Seifert. We are talking about policy rather than expertise in a given area. I think it would be interesting to know, if you could find out and possibly the Chair would make this request?

Admiral Bell. Yes, sir. I will go back and try to discuss this with Admiral Allen to the degree that this has been interfaced and see if we can provide that for you.

[The following was received for the record:]

Program Proposals

The two programs mentioned are basically a Coast Guard initiative in the form of proposals provided to the USPHS as well as to Maritime unions, management, Maritime schools, and other interested groups in the maritime community. The USPHS or any other interested group is expected to participate in the policy making process by comments or suggestions involving these proposals. The USPHS has a program called "Seafarers' Health Improvement Health Program" (SHIP) which serves to coordinate and access input from the Maritime community. This information is used in formulating our programs.

In a further effort to provide greater involvement of the USPHS in the policy and formulation of these programs, the Chief, Programs Coordinating Branch of the Division of Hospitals and Clinics, USPHS, and Chairman of the SHIP Program was offered the opportunity for orientation to the program proposals generated by the Coast Guard in order to assist in the ultimate program ("Physical Standards" and "Medical Care at Sea") formulation. This offer, so far, has been declined.

Mr. Seifert. Because there seems to be some question by the PHS as to what standards will be established by the Coast Guard, and one assumes when we are dealing with public health or the health of merchant seamen, that there should be some relationship between you, or among all of you.

Admiral Bell. I am informed that we are members of SHIP, the acronym you faced just prior to my appearance. But in answer to your exact question, I will be glad to go back and try to find out. I rely on the Public Health Service doctors assigned to us, and I presume that they would call on whatever expertise they need through their parent service. I will clarify that, sir.

Mr. SEIFERT. This upgrading that you are talking about, how important is it to have a Public Health Service Hospital System in place in order to implement this program?

Let me put it another way. How much reliance upon the Public Health Service System do you anticipate placing for implementation of this program?

Let me put it another way. Is it necessary to have a medical care delivery system on shore, knowledgeable of the needs of merchant seamen, in order for this system to be effective?

Admiral BELL. Yes, sir, I would say it is.

Mr. SEIFERT. Do you know any system, other than the Public Health System, that would answer that particular need?

Admiral BELL. No, sir. Now, sir, we have to utilize in certain instances non-PHS doctors because the PHS personnel are not available. This requires quite an education on our part to take a civilian physician and translate terms for him in an arena where he can adequately communicate.

Mr. SEIFERT. What circumstances?

Admiral BELL. Alaska. Alaska is very difficult, also, the northern coast of California is out of direct voice communication with San Francisco. You have large areas of the country where just voice communication with a PHS physician is not possible.

Mr. SEIFERT. A satellite communication system eliminates that type of problem?

Admiral BELL. I cannot say, sir. Our concern here is to get someone trained onboard ship who is adequate enough in medical terminology and radio communication procedures so he can talk to the doctor ashore. We feel that that is the biggest failing right now in the system.

The CHAIRMAN. Admiral, you have them on your icebreakers?

Admiral BELL. Yes, sir, for extended deployment.

The CHAIRMAN. Are these PHS?

Admiral BELL. Yes, sir, for extended deployment. For many years this was correct. However, the rising cost of physicians coupled with a determination that Coast Guard physician assistants were qualified to handle most medical emergencies experienced on these ships led to the discontinuance of assigning physicians to these vessels. These physician assistants are commissioned warrant officers with a minimum of 2 years formal medical training. At the present time, due to the success of this program, plans are to continue with this program.

The CHAIRMAN. Thank you.

Mr. SEIFERT. Thank you.

Mr. LOWRY. Mr. Bruce.

Mr. BRUCE. Admiral, I detect a little subtlety in your presentation in that what you are providing to IMCO for the July meeting are qualifications for health care providers——

Admiral BELL. Yes, sir, you are correct.

Mr. BRUCE. If you fail in your July meeting with IMCO, is it your intention to act unilaterally in establishing those qualification standards?

Admiral **Bell**. Yes, sir. I do not presume that we are going to fail because of the groundwork that we did in January. At the meetings I attended, I thought we had good agreements by all the members that this was the type of care that would satisfy most countries' demands, both the management and labor demands for onboard medical care.

Mr. **Bruce**. Onboard medical care meaning medical care provided to the mariner?

Admiral **Bell**. Yes, sir.

Mr. **Bruce**. What efforts are underway to establish qualification standards for seamen such as for-entry ratings?

Admiral **Bell**. Sir, there is none that I am aware of. The individual countries would be required to validate the physical standards for the people they licensed and, to my knowledge, there is no discussion whatsoever of an international medical standard.

Mr. **Bruce**. Your only effort presumably underway is what you describe, through your acronym, as a "sailors" program?

Admiral **Bell**. Yes.

Mr. **Bruce**. Some years ago, Admiral Craik, late of the Coast Guard and the Texas Maritime Academy undertook such a system. I believe he called it Profile. Has your plan, identified by the acronym "sailor" received any greater endorsement from labor and industry than the previous one?

Admiral **Bell**. I am advised that—I was not aware of Admiral Craik's program.

To my knowledge, in the discussions, yes, this has received both labor and management's endorsement. Now, that is not saying that everybody signed on the bottom line for it. But nobody has criticized the program and we generally have gotten encouragement to proceed with it. I therefore presume that is endorsement.

Mr. **Bruce**. One of the difficulties that I recall was with regard to seafarers now employed. Will your jurisidiction extend to those now employed?

Admiral **Bell**. No, sir, we have not gotten into that. That is why I say in my statement that those things still have to be developed. The only time I know that we are, that has turned into a problem, is when you start talking about certain Occupational Safety and Health Administration (OSHA) standards that seafarers presently employed that become very important. That has not arisen in this arena, to my knowledge, but we will have to address that problem as we proceed.

Mr. **Bruce**. In your statement you refer to a shoreside doctor in radio communication. Is there any significance to that? Is there any intention to establish some sort of center with a doctor in being from such as Public Health Service?

Admiral **Bell**. I guess the statement—no; it is not an intent to establish anything that does not exist now. It was recognizing that we receive our expertise and guidance from the Public Health Service at the moment, but that we are hindered in doing that, usually because of a lack of training of people onboard ship. It is also recognition we are not trying to put doctors on ships. We are trying to develop a person who knows how to do things when directed to but would not make a decision as to when to do them, as a doctor would.

Mr. Bruce. What about doctors in radio communications? Doctors in a community center of some sort?

Admiral Bell. No, sir, we do not have the doctor standing by. But we can phone patch to any medical facility, which we do. The coordination center does not have a doctor standing by; he just dials the phone and patches into the local medical facility and puts him right in direct communication with the ship.

Mr. Bruce. One of the difficulties identified by witnesses in testimony has been the time delay between the receipt of a call for assistance and the time by which you ultimately contact a Public Health physician.

Is there any effort underway to reduce that 2 or 3 hours' time delay?

Admiral Bell. I cannot speak to what the witness was addressing. Yes; there are time delays in certain times. One of the problems, as I have said before, is how to find out how we get a set of symptoms from somebody aboard ship that are not well defined. There is a delay in trying to establish what the illness is, so that the doctor can respond to it. We have not, to my knowledge, had extensive communication delays. It is usually trying to establish what is wrong with the man on the ship so that the doctor has enough knowledge to either prescribe or recommend evacuation.

Mr. Bruce. Would it be beyond reason to suggest that a direct link with a Public Health Service facility might reduce that time delay if a doctor conducted that?

Admiral Bell. Yes, sir. As a general statement, yes. But unless you have somebody aboard ship who can describe the symptoms in terms the doctor understands, that is the first goal we have to achieve. Because I do not know if I am being responsive, but my concern is still the time of communications is critical. Having somebody to feed the doctor enough symptoms so that the doctor has learned to respond to. Unless that happens, there is a large frustration factor between the two.

Mr. Bruce. One final question. Where you have Marisat communications receiver sets are they linked directly to a Public Health Service hospital?

Admiral Bell. I cannot say, sir.

Mr. Bruce. That is supposed to be the way of the future, Marisat or satellite communication?

Admiral Bell. Yes, sir, I would say that is a correct statement, but cost etimates at the present time are unknown. We will be watching the growth of these systems and if they prove to be practicable for our needs, I am sure we will be considering the use of these systems.

Mr. Bruce. Thank you.

Mr. Lowry. Any further questions?

Mr. Seifert. I have one but I think you can probably supply it for the record, Admiral. That is could you tell us how many evacuations have been made on an annualized basis and what the cost per evacuation is?

Admiral Bell. Yes, sir, I will be very comfortable supplying it for the record. I just do not know personally.

[The following was received for the record:]

COST OF EVACUATIONS

In 1978 the Coast Guard performed 528 medical evacuations. We estimate the cost of each medivac at $3,500, excluding the unanticipated accident costs.

For fiscal year 1978 there were 874 cases involving medical advice or medivac reported to the Coast Guard where Coast Guard assistance was required. These cases involved cargo, passenger, tankers, fishing and towing/salvage vessels. Approximately 1,781 lives saved were attributed to Coast Guard assistance.

The following is a breakdown of assistance rendered according to class of vessel and nationality.

BREAKDOWN OF ASSISTANCE

	Medivac		DH Medico	
	Number	Percent	Number	Percent
U.S. commercial vessels (cargo, tanker and passenger)	158	30	86	21
Foreign flag commercial vessels (cargo, tanker and passenger)	113	21	194	58
Other foreign and domestic vessels (mostly fishing vessels)	257	49	66	21
Total	528		346	

The following is a breakdown of all medivacs and medical messages for both foreign and domestic tankers, cargo and passenger ships and location.

	Medivacs				DH Medico			
	United States		Foreign		United States		Foreign	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
ICW (miles offshore):								
0 to 3	50	32	20	17	8	9	1	0.5
3 to 10	63	30	21	27	2	3	4	2
10 to 20	17	10	25	22			3	1.5
20 to 50	6	3	8	7	6	7	1	1.5
50 to 100	9	6	7	6	6	7	11	6
100 to 150	5	3	4	3	1	2	7	3
150 to 300	8	5	9	8	6	7	17	8
More than 300	1	.3	5	7	7	65	146	80

Of the 528 medivac's, 108 were performed by CG aircraft (Approximate cost $3,500.00 ea.); 51 from U.S.-flag vessels; 57 foreign flag.

Mr. LOWRY. Admiral Bell, thank you very much for your meaningful testimony. The committee appreciates it.

We will call our next panel who will be Dr. William Walsh, Mr. Marvin Pitkin, and Mr. Edward Martin.

Thank you, gentlemen, for taking your time to appear before us. We, too, have copies of your statements for the record. The staff informs me that Dr. Walsh will need to leave fairly soon, so I would like to call on Dr. Walsh first to make his statement.

STATEMENTS OF A PANEL CONSISTING OF DR. WILLIAM B. WALSH, PRESIDENT AND MEDICAL DIRECTOR, PROJECT HOPE; EDWARD J. MARTIN, DIVISION MANAGER, INMARSAT, COMSAT; AND MARVIN PITKIN, ASSISTANT ADMINISTRATOR FOR COMMERCIAL DEVELOPMENT, MARITIME ADMINISTRATION, DEPARTMENT OF COMMERCE

Dr. WALSH. Thank you, Mr. Chairman.

I am Dr. William B. Walsh, and I am president and founder of the People-to-People Health Foundation, Inc., of which Project Hope is the principal activity. I am pleased to be able to present to you this morning our views on medicine and the satellite. My remarks will be brief because I believe the accompanying monograph, Medicine and the Satellite, which I co-authored, describes in adequate detail our experience with the use of the satellite on board the SS *Hope* in 1973.

I should say parenthetically at the outset that the year after this experiment was conducted the hospital ship itself was retired as Project Hope continued its growth in long-term shore-based health teaching programs. Hope has been at work now in 26 countries, including the United States. This year we have established in Virginia the Hope Health Sciences Education Center. In addition to serving as the base for our continuing programs abroad, this new center now serves as a forum for the analysis of health care delivery problems overseas and here at home.

It must be remembered that in 1973 we were still in the early days of the development of this diagnostic tool. Comsat had utilized the same instrumentation onboard two other vessels at this time, and I believe their experience was similarly rewarding. The supporting equipment, such as the slow-scan TV and the other telecopiers were, I am certain, more primitive than they are today, 6 years later. Nevertheless, we were able to demonstrate a variety of effective uses to which transmissions extended from our ship off the coast of Brazil to a variety of American medical institutions.

X-rays, electrocardiograms, hematology slides, and visual patient demonstrations were proven to be possible and effective.

Consultants in such diverse areas as the Mayo Clinic in Rochester, Minn., our own office in Washington, and the Boston Children's Hospital, Boston, Mass., were all able to participate. We were interested in demonstrating that the satellites could be used not only as a diagnostic tool but also as a means of improving international teaching techniques in the health fields.

It is my understanding that your hearing is devoted to the application of different procedures in the care of merchant seamen. There are many factors for your committee to consider in this regard. They are:

First, the economy of such a technique. Is it worth the expense for a relatively small number of merchant seamen with occasional problems?

Second, what would the legality of the impressions gained by diagnosis or consultation by this means be in regard to workmen's compensation?

Third, what would be the attitude of the seamen themselves to the acceptability of diagnosis and treatment by such remote means?

Fourth, what would be the willingness or the liability of a physician prescribing from some 5,000 miles away for an illness only visualized by a satellite or the receipt of transmissions by electronic means?

Fifth, are we to assume that the receiving stations will be primarily the Public Health Service Hospitals which have the primary responsibility for the health care of the merchant seamen, or would it be necessary to establish receiving facilities at other private institutions?

All of these judgments will have to be made by those directly involved, and I would not be qualified to make a firm recommendation. As a result of our experience in the utilization of merchant marine crews aboard the SS *Hope*, for a period of approximately 15 years, I would caution the committee that the physical qualifications of the merchant seaman must be carefully ascertained before the men ever go to sea.

It was our experience that many physically unqualified men were assigned and given clearance by the Public Health Service physicians, when these men would spend a substantial part of each of our voyages unable to perform their duties because of preexisting infirmities. On many occasions we pleaded with both the union representatives and the Public Health Service for permission for and acceptance of physical reviews of seamen by our own professional staff. This request was made because so many men were sent to the SS *Hope* with disqualifying illness which not only prevented them from doing their jobs, but which in the long term became extremely costly to Project Hope and the payment of workmen's compensation and claims of aggravation of preexisting illnesses.

No satellite or other long distance method of diagnosis and treatment will be of any value unless strict standards are enforced by the Public Health physicians responsible for the clearance of these seamen for duty.

I realize that my testimony was requested primarily for consideration of the satellite as a tool for diagnosis and treatment, but I cannot help but accentuate the need as outlined above.

No technological progress will replace careless or poor medicine. The cost to the taxpayer and to the operators of the American Merchant Marine have a direct relationship to these facts. The role the satellite could play to remedy or aggravate that situation rests wholly upon the competence of the Public Health Service and the cooperation of the members of the various maritime unions.

Thank you very much, and I will be happy to answer your questions.

I am delighted to see the initiative taken by the Coast Guard, and the projects they have suggested. It is long overdue.

Mr. LOWRY. Thank you, Doctor, that was, of course, our thought, as we were listening to your testimony about the Coast Guard's previous testimony.

I would imagine that we are going to need to look at this new technique, and then, maybe a year from now come back and evaluate that, and hopefully to pick up on this problem.

The gentleman from Texas.

Mr. DE LA GARZA. No questions.

Mr. LOWRY. Mr. Donnelly?

Mr. DONNELLY. No questions.

Mr. LOWRY. Counsel?

Mr. SEIFERT. I would assume that many of the questions, which will be addressed to the panel, can be answered by any of your colleagues at the table. So I will just address myself to the ones that are unique to your statement, and the ones that are the most troublesome.

You suggest, at the very end, at least there is a hint, to me, that you perhaps find that PHS medicine is being practiced poorly. Are you suggesting that poor medicine, or carelessness is being practiced by the Public Health Service?

Dr. WALSH. I believe I could answer that in an affirmative fashion. Certainly in regard to our experience, I can tell you we were sent seamen with intractable peptic ulcers who were sent back to us, year after year, I can tell you of patients with obesity and severe hypertension to such a degree that they were put to bed and had medications administered by hypodermic, by the Public Health Service physicians, so that they could get one basic reading of a diastolic blood pressure which would enable the man to be qualified for duty.

I can cite still another, and Lord, I could go on all morning, of a man who has been granted permanent disability for an alleged back injury by the Public Health Service while working on the *Hope*. We settled his claim for $28,000. Two years later he was suddenly requalified for duty on the *Hope* by a Public Health Service physician. Within 2 weeks he was within our infirmary again, making a new claim.

I could go on and on with this type of thing. We never could understand the degree of the problem involved. Most merchant marine companies, for example, have their own medical department. I listened to witnesses this morning who keep talking about the unusal problems of seamen, that regular physicians would be making judgments in circumstances with which they are not familiar. This is simply incorrect.

Since when is a coronary occlusion an unusual disease? This is not a disease that is rare or strange. I think that in many instances, if the law permitted, where you had to have a joint opinion, of say the operating agent's physicians, as well as the Public Health Service, that you would have—that you would have a lessening of liability, and a higher degree of protection for the seamen. These men are not aware sometimes of the seriousness of their illness, because they are not educated in this field. They go to sea because they need a job. They are not aware that they may even be endangering their own lives, and then they are cleared for service.

Chronic alcoholism, another illness which has been avoided in the testimony this morning, is a serious problem when you have people at sea.

Mr. SEIFERT. Unfortunately, you will not be able to be here the rest of the day, but I noted that there is testimony which will follow, which deals with the concern of alcoholism among our merchant seamen.

The other question that stands out in your testimony is the concern for the liability of the physician, a malpractice concern that you expressed. You are a physician?

Dr. WALSH. Yes.

Mr. SEIFERT. Now, if you were the only diagnostician, and you were 5,000 miles away, and you were communicating with a vessel by satellite, based upon your own feeling as a physician, and your experience on Project Hope, would you not give that diagnosis?

Dr. WALSH. Up until you added the last phrase, I think a physician would. From my experience, with 15 years at the *Hope*, and 15 years of paying liability claims, I would now be extremely hesitant, unless the diagnosis is so clearcut as to absolutely provide no opportunity for recrimination.

You know, you can only afford so many lawsuits a year brought to you by attorneys, representing seamen for alleged illnesses or alleged malpractice.

I think this is what the operators have put up with primarily, because in many instances, legally, a patient, or a seaman who is sent to sea, and given clearance by the Public Health Service, who is not fit to be at sea, will have an aggravation of illness, and he does have a legitimate claim, and I do not blame him for filing the claim.

The problem is we should never have had him in the first place.

Now, I think that since the Government physicians are self-insured, if the terminals were in a Public Health Service Hospital, there would be no need for fear of giving an opinion. So there is no problem to that.

I think the other thing, the other aspects, if they need someone versed in professional language on the ship, you know, we do not have to reinvent the wheel. You have physician assistants, you have nurse practitioners, you have highly qualified corpsmen in the military services, including the Army the Navy, and the Air Force who have curriculums and training already that are excellent. If this is what the Coast Guard is looking for, this is already available to them through the other services. If you wanted to assign men like this to a merchant ship, they could certainly render excellent primary care service.

Mr. SEIFERT. Are you suggesting that we place uniformed personnel aboard vessels to provide medical care?

Dr. WALSH. If there was nothing else, I suppose the same type of corpsmen would be available to the Public Health Service. These men can certainly talk the language over the satellite that the admiral was worrying about. These men are trained.

We are all at the mercy, if we have a coronary, of when the ambulance comes, you have someone far less trained than these men.

Mr. SEIFERT. Since the bulk of my questions relate to satellite communications, I think I will wait until the other witnesses have made their presentations.

Mr. LOWRY. Minority counsel?

Mr. BRUCE. No questions.

Mr. LOWRY. If your schedule requires you to leave?

Dr. WALSH. Thank you, I will stay until about a quarter to 12.

Mr. LOWRY. Mr. Pitkin?

Mr. PITKIN. Mr. Chairman and members of the committee, I am Marvin Pitkin, Assistant Administrator for Commercial Development for the Maritime Administration. I appreciate the opportunity to testify before the committee with regard to the use of maritime satellites for medical services at sea, as well as MarAd's programs concerned with the whole health care of American crews.

I have submitted a written statement, and with your permission, I will extract from it to save time.

[The following was received for the record.]

STATEMENT OF MARVIN PITKIN, ASSISTANT ADMINISTRATOR FOR COMMERCIAL DEVELOPMENT, MARITIME ADMINISTRATION, U.S. DEPARTMENT OF COMMERCE

Mr. Chairman and members of the committee, I am Marvin Pitkin, Assistant Administrator for Commercial Development for the Maritime Administration. I appreciate the opportunity to testify before this Committee with regard to the use of maritime satellites for medical services at sea. I should like to do so in two steps. In the first, I should like to provide this distinguished Committee with a review of MarAd's ten year old research and development program in the field of maritime satellites. In the second, I will discuss our specific views towards the use of satellites for medical purposes at sea.

The subject of satellite telecommunications services has been of high interest to the Maritime Administration since 1969. At that time the Maritime Administration performed an assessment to identify the possible application of U.S. technology to improve the productivity and safety of the U.S. maritime fleet. Satellite navigation and communications were identified as one such program which offered high potential benefits with respect to costs to U.S. fleet operators, and, as a consequence, a research program was initiated in this area. This program subsequently comprised four phases and continues through this date in this program.

The objectives of the MarAd R&D program are threefold: First, to extend to U.S. ships the high quality, real-time communications services then provided between locations ashore; secondly, to enable continuous, accurate ship location information to be available for use both by ship and shore stations; and thirdly, to bring into use by U.S. companies new ship management techniques that utilize the advanced technology provided by the satellite services.

The first phase was completed in June 1971 and resulted in definition of desirable satellite communications concepts, an assessment of preliminary cost and benefits and a program to reach the previously stated objectives. During Phase I we also conducted at sea tests at L-Band frequencies, which were subsequently assigned internationally for this purpose. These tests proved successful and established that this frequency band would prove effective.

In Phase II, conducted between 1971-1973, equipment was put aboard nine (9) U.S. flag test ships and an experimental Maritime Communications Center (MCC) was built at the National Maritime Research Center (NMRC) at Kings Point, New York. A five month operational test using two NASA Advanced Technology Satellites (ATS-1 and ATS-3) was conducted. During this at sea test period U.S. shipping companies conducted 125 experiments using advanced communication and navigation techniques. These involved more than 600 ship-days of testing and provided for the transmission of 5,000 messages used in the various experiments.

NASA satellites ATS-5 and ATS-6 were available to MarAd for Phase III experiments for 300 hours during the August 1974 through May 1975 time period. Phase III initiated a new series of fleet management tests to determine the economic worth of the satellite communications to the marine uses. Because of ATS-6's particular antenna characteristics, coverage was limited to ships in the North Atlantic Ocean. Two ships participated in the tests. Significant technical data on both communications and navigation system capabilities and benefits.

The MarAd program is considered to have been one element in the decision of the U.S. companies to initiate maritime satellite service (MARISAT) in advance of international planning. With the commercial availability of MARISAT in the summer of 1976, MarAd's Phase IV Ship Data Communications Systems (SDCS) Project was initiated cooperatively with 10-U.S. flag ocean shipping companies and the common carrier communication companies involved in MARISAT. The objective of Phase IV is to further develop the ability of the U.S. flag ocean carrier companies to improve the technical and financial performance of their ships, from both a planning and operational perspective while utilizing modern ship-to-shore computer/communications technology. Initially MarAd's prototype Maritime Communication Center (MCC) installed at our Research Center in Kings Point, New York was used as a shoreside laboratory for these experiments.

The MCC is a laboratory utilizing a computer system that provided an interface between the MARISAT communications services and the corporate offices of the ten U.S. flag ocean shipping companies participating in the project. It allowed for a controlled transmission of data and information between any of the participating ships and the MCC, with editing and return transmissions as required. Such data and information could be either stored at the MCC under proprietary protection, forwarded automatically to the shipping company corporate office or retrieved on demand.

The MCC served as a successful prototype center for the 10 shipping companies through twenty-six months of operation (from February 1976 through April 1978). The development and operation of the MCC was provided by Computer Sciences

Corporation (CSC) under contract to the Maritime Administration. CSC provided us with a comprehensive evaluation of the potential performance of maritime satellite communications from a fleet management perspective in a final report of that name which is now available.

In 1978 the MCC was phased out and replaced with an alternate computer-based system to facilitate the continuing fleet management development activities of the ten U.S. flag ocean shipping companies under the SDCS Project. As of February 21, 1978, this system has been provided to the 10 companies through the General Electric Mark III international time sharing computer service under a separate contract between MarAd and GE. The new system provides most of the functions of the Kings Point MCC, as well as some additional functions, for roughly one-tenth of the cost with significantly superior reliability.

The participating U.S. flag ocean companies have completed the transition from the Kings Point MCC to the GE system. It is expected that each company will evaluate the effectiveness of the GE system and ultimately, either continue this service for their own account or seek alternate fleet management development computer services.

This Phase IV effort will be completed on July 28, 1979, and bring to an interim conclusion some ten years of highly effective research and development by MarAd in this important area.

The MarAd program is considered to have been an important element in the decision of the U.S. companies to initiate a Commercial Maritime Satellite Service (MARISAT) in advance of an International Maritime Satelllite System (INMARSAT) currently being ratified by member nations.

It might be interesting to note that this program from the concept formulating period of 1969 through the current year, has been effectively managed and implemented by a Government staff of between one and two persons.

As a result of these efforts, over a 10 year long period, we have gone from a conceptual and experimental system design to participation in an active Commercial Maritime Satellite Communications System (MARISAT)—which in turn has led to the U.S. assuming a major share in the forthcoming International Maritime Satellie System (INMARSAT).

With respect to the specific interest of this Committee on the status of the health care of U.S. seamen and the impact that satellite communications may have on the ability to provide this service; today, as in the past, the Maritime Administration is actually engaged in a number of programs concerning the health and welfare of the U.S. seamen. These include an extensive analysis of seamen injury and illness data to ascertain trends or patterns of shipboard health and safety; environment as correlated with ship type, age of seafarer and job type. Copies of the interim reports of this program are submitted for the record. We have also undertaken a limited study to ascertain the impact of a physician's assistant on the accident and illness rates aboard selected vessels. A copy of the report entitled "The Maritime Physician's Assistant—Effect on the Frequency and Distribution and Illness Reports from U.S. Merchant Ships" is submitted for the record.

At the present time we also have other studies underway. One a major study relating to asbestos particles aboard ships at sea. Another recently established is a major study effort underway with the Seafarers International Union and other maritime unions to ascertain means to improve the quality of life at sea, which includes among other topics: analysis of the effect on seafarers of noise and vibration, impact of variations of work cycles, health safety requirements, influences of isolation, fast turn-arounds, long voyages, etc., to mention only a few tasks.

With regard to the specific subject of satellite communications and their ability to improve medical services at sea, it is our position that a pilot program undertaken by MarAd in 1975 served to demonstrate the technical feasibility of satellite systems to communicate vital health data from ship to shore. At that time, in March of 1975 with part of its Phase III program, MarAd conducted a series of ship-to-shore communications tests using the MARISAT Atlantic Satellite, whereby the emergency room of the North Shore Hospital in Manhasset, New York was in direct contact with the SS LASH ATLANTICO in Mid-Atlantic for the purpose of demonstrating the ability and quality of satellite communications to transmit medical data services and further to demonstrate the EKG facsimile information. The report of this pilot program entitled "Feasibility Study for the Development and use of the Satellite Communications System to Provide Shipboard Emergency Medical Services" is herewith submitted for the record. This study concluded in April of 1976 that it was feasible technically to extend quality medical care to those at sea via maritime satellite communications, provided, firstly, that there was a properly trained emergency medical technician among the ship's personnel; provided, secondly, that he or she had modern medical equipment aboard; and provided, thirdly and most importantly, that there was a qualified doctor ashore providing advice, consultance and direction as part of a regular service. Unfortunately, these three required capabilities just do not exist to the degree necessary in today's U.S. maritime community. For these and other reasons a $637,000 proposal to us from the North Shore University Hospital in Manhasset, New York, dated July 27, 1977, to establish a medical services satellite project (MEDSAT) was carefully reviewed by MarAd.

A seminar on this subject was held at the National Maritime Research Center at Kings Point on September 20, 1977, to discuss this problem and present this proposal to the maritime industry. In response to a request from the maritime industry groups—both labor and management—participating in that seminar, the proposal was sent to 43 such organizations for their review and comment. While most comments acknowledged the importance of the subject of health care at sea, few thought that satellite technology alone would lead to its improvement and many had objections to the scope and approach of the proposal.

We thus informed North Shore University Hospital on January 4, 1978, in a letter to Dr. Gary Wadler, that due to lack of industry commitment to this proposed project, we were unable to accept the proposal as submitted. In a subsequent meeting in our offices with Dr. Wadler, we reviewed our decision with him and discussed the need to develop a maritime industry commitment to a more fundamental approach to improving health care at sea if his organization wished to pursue the matter further. We have not heard further from North Shore University Hospital in this regard.

In order to more fully illustrate the position of the maritime industry on this matter, I have selected two responses to our survey, the first from a major containership operator and the second from a major tanker operator. The first set of excerpts states, I quote:

"We have concluded that it is probably too advanced for the present state of merchant shipping and represents too ambitious an initial effort.

"We would like to point out that from a technological point of view that the use of the service as described would be both awkward and expensive for vessels operating world-wide as opposed to vessels operating in essentially domestic trades.

"Additionally, we feel that there is so much margin for improvement in medical training of shipboard officers that an initial effort would be better made in that direction and we would very much favor such an approach. We feel that a program begun in that fashion would represent a more constructive and beneficial use of taxpayer funds and be more likely to provide improved results in medical care over the near term.

"The possibility of utilization of the full program, in our judgment, is best left to reconsideration after an initial program of upgrading ship's officers medical skills and operating within the existing health coommunication network.

"In any event, our vessels are presently not equipped with the required communication equipment and consequently would not be able to participate in the full program at this time." (A major containership operator.)

The second set of excerpts is from a major tanker operator, as follows:

"We cannot recommend proceeding with the project. Our ships operate relatively close to shore and under our present system of telegraphy, telephonics and helicopter service, amplification of our present arrangements would be difficult to justify.

"The proposal is an expensive, involved system for patient care of seamen which really is not in urgent demand, based on our experience. The training program to make this effective would be enormous, would require trained medical personnel on every ship, would increase the number and scope of medications which are in the ship's medicine chest, and would be very expensive—far beyond the stated costs in this project."

We next received a similar proposal, this time for $450,000, from the Staff Officer's Association in Hoboken, New Jersey, dated June 7, 1978, to establish a Shipboard Medical Satellite Communications Project (MEDSHIP). Again, we carefully reviewed this proposal in the light of our previous experiences and our own R&D budget limitations. After consideration of these factors, we ultimately concluded that there was an insufficient expression of need and support by the industry and other concerned Government organizations to justify acceptance of this proposal within our funding priorities. We informed the Staff Officer's Association of this decision in a letter to Mr. Burt Lanpher dated July 27, 1978.

More recetly, in response to a letter to us from Mr. Lanpher of February 28, 1979, we again explained our position on this matter in a letter dated April 22, 1979. In this letter we stated that we would be prepared to support a project for shipboard medical satellite communications provided that a significant commitment to such a project could be demonstrated by both maritime industry and labor (including cost sharing). In addition, we feel that the U.S. Public Health Service and the U.S. Coast

Guard would have to be intimately involved, to the point of being equal partners with the Maritime Administration (⅓-⅓-⅓) in terms of Federal Government funding and responsibility.

In pursuit of this objective, we are now actively working with the U.S. Public Health Service and the U.S. Coast Guard in the Seamen's Health Improvement Program (SHIP) sponsored by the Public health Service. In conclusion, we remain actively interested and involved in this and any other application of maritime satellite communications, where it can improve the productivity and safety of the U.S. maritime fleet.

Thank you.

Mr. PITKIN. The subject of satellite telecommunications services has been of high interest to the Maritime Administration since 1969. At that time the Maritime Administration performed an assignment to identify the possible application of U.S. technology to improve the productivity and safety of the U.S. maritime fleet. Satellite navigation and communications were identified as one such program which offered high potential benefits with respect to costs to U.S.-fleet operators. As a consequence, a research program was initiated in this area. This program subsequently comprised four phases, and continues through this date, in this program.

The objectives of the MarAd research and development program are threefold: First, to extend to U.S. ships the high-quality, real-time communications services then provided between locations ashore; second, to enable continuous, accurate ship location information to be available for use both by ship and shore stations; and third, to bring into use by U.S. companies, new ship management techniques that will utilize the advanced technology provided by the satellite services.

The first phase was completed in a June 1971 and resulted in a definition of desirable satellite communications concepts, an assessment of preliminary cost and benefits, and a program to reach the previously stated objectives.

In phase II, conducted between 1971 and 1973, equipment was put aboard nine U.S.-flag test ships and an experimental Maritime Communications Center (MCC) was built at the National Maritime Research Center (INMRC) at Kings Point, N.Y. A 5-month operational test using two NASA advanced technology satellites (ATS-1 and ATS-3), was conducted. During this at-sea test period, U.S. shipping companies conducted 125 experiments, using advanced communication and navigation techniques. These involved more than 600 ship-days of testing and provided for the transmission of 5,000 messages used in the various experiments.

Phase III initiated a new series of fleet management tests to determine the economic worth of the satellite communications to the marine uses. These were NASA satellites ATS-5 and ATS-6, which were available to the MarAd for such phase III experiments during August 1974 through May 1975.

The MarAd program is considered to have been one element in the decision of the U.S. companies to initiate maritime satellite service (Marisat) in advance of international planning. With the commercial availability of Marisat in the summer of 1976, MarAd's phase IV ship data communications system (SDCS) project was initiated cooperatively with 10 U.S.-flag ocean shipping companies and the common carrier communication companies involved in Marisat.

Initially MarAd's prototype Maritime Communication Center (MCC) installed at our research center in Kings Point, N.Y. was used as a shoreside laboratory for these experiments.

In 1978, the MCC was phased out and replaced with an alternate computer-based system in order to facilitate the continuing fleet management development activities of the 10 U.S.-flag ocean shipping companies under the SDCS project.

This phase IV effort will be completed on July 28, 1979, and bring to an interim conclusion some 10 years of highly effective research and development by MarAd in this important area.

Leadership of subsequent phases will be transferred to the Council of American Flag Shipping Operators (CAFSO), with MarAd backup.

It might be interesting to note that this program, from the concept-formulating period of 1969 through the current year, has been effectively managed and implemented by a Government staff of between one and two persons.

As a result of these efforts, over a 10-year period, we have gone from a conceptual and experimental system design to participation in an active commercial maritime satellite communications system (Marisat), which in turn has led to the United States assuming a major share in the forthcoming International Maritime Satellite System (Inmarsat).

With respect to the specific interest of this committee on the status of the health care of U.S. seamen and the impact that satellite communications may have on the ability to provide this service; today, as in the past, the Maritime Administration is actually engaged in a number of programs concerning the health and welfare of the U.S. seamen. These include an extensive analysis of seamen injury and illness data to ascertain trends or patterns of shipboard health and safety; environment as correlated with ship types, age of seafarer, and job type. Copies of the interim reports of this program are submitted for the record.

[The information mentioned was received and placed in the hearing record files of the committee.]

Mr. PITKIN. We have also undertaken a limited study to ascertain the impact of a physician's assistant on the accident and illness rates aboard selected vessels. A copy of the report entitled "The Marine Physician's Assistant: Effect on the Frequency and Distribution of Illness and Injury Reports from U.S. Merchant Ships" is submitted for the record.

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Mr. PITKIN. At the present time we also have other studies underway. One, a major study relating to asbestos particles aboard ships at sea. Another, recently established, is a major study underway with the Seafarers International Union and other maritime unions to ascertain means to improve the quality of life at sea, which includes, among other topics: Analysis of the effect on seafarers of noise and vibration, impact of variations of work cycles, health safety requirements, influences of isolation, fast turnarounds, long voyages, et cetera, to mention only a few tasks.

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Mr. PITKIN. This study, concluded in April of 1976, stated that it was feasible, technically, to extend quality medical care to those at sea via maritime satellite communications, provided, first, that there is a properly trained emergency medical technician among the ship's personnel; provided, second, that he or she has modern medical equipment onboard; and provided, third, and most importantly, that there is a qualified doctor onshore, providing advice, consultance, and direction as part of a regular service.

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More recently, in response to a letter to us from Mr. Lanpher of February 28, 1979, we again explained our position on this matter in a letter dated April 22, 1979. In this letter we stated that we would be prepared to support a project for shipboard medical satelite communications, provided that a significant commitment to such a project could be demonstrated by both maritime industry and labor, including cost-sharing. In addition, we feel that the U.S. Public Health Service and the U.S. Coast Guard would have to be intimately involved, to the point of being equal partners with the Maritime Administration—one-third, one-third, one-third—in terms of Federal Government funding and responsibility.

In pursuit of this objective, we are now actively working with the U.S. Public Health Service and the U.S. Coast Guard, in the Seamen's Health Improvement Program—SHIP—sponsored by the Public Health Service.

In conclusion, we remain actively interested and involved in this and any other application of maritime satellite communications, where it can improve the productivity and safety of the U.S. Maritime Fleet.

Thank you very much.

Mr. de la Garza [presiding]. Thank you very much.

Mr. Martin?

Mr. Martin. Thank you very much, Mr. Chairman. My name is Edward J. Martin, and I am division manager, INMARSAT, Communications Satellite Corp.

I am very pleased to be able to testify before your committee, and in the case of Mr. Pitkin, I intend to abbreviate my written testimony, which has been submitted to your committee.

Mr. de la Garza. Without objection, your full statement will be inserted in the record.

[The following was received for the record.]

Prepared Statement by Edward J. Martin, Communications Satellite Corp.

Thank you Mr. Chairman. My name is Edward J. Martin and I am Division Manager, INMARSAT, Communications Satellite Corporation.

I am very pleased to be able to testify before your Committee on the care of U.S. merchant seamen aboard ship and on shore, including the feasibility of satellite ship-to-shore telecommunications. The improvement in communications with vessels on the high seas has been a matter of great interest to Comsat and its subsidiary, COMSAT General, for several years. As I think you are aware, we began intensive pioneering efforts in 1973 that led to the first satellite system devoted to maritime telecommunications services, the MARISAT System, which was brought into service in 1976. We feel very fortunate to have had the opportunity to develop this improvement in communications, which has important implications for the health and safety of merchant seamen worldwide.

I should like to review the genesis and current status of maritime satellite telecommunications services and to demonstrate how such services have been and will continue to be of great benefit to seamen.

In 1973 Comsat submitted a proposal and was awarded a Contract to provide satellite communications services to the U.S. Navy. The satellites selected to provide the Navy service had sufficient weight and power capability to permit the incorporation of additional equipment for the simultaneous provision of commercial maritime services. A suitable communications system was designed and developed on an expedited basis and actual commercial service was introduced in mid-1976 in the Atlantic and Pacific Ocean regions. This new service provided for the first time, high quality, essentially undelayed telephone and telex contact between shore points and vessels. In fact, the system incorporates a priority feature which assures immediate access for distress calls. The demand for commercial services has grown steadily since their introduction almost 3 years ago.

COMSAT General assumed responsibility for the development, management and operation of the MARISAT System at an early stage. Pursuant to an FCC Order, three other carriers, RCA Globcom, Western Union International and ITT Worldcom, opted for minority holdings in the new venture. COMSAT General has an 86.29 percent ownership interest, and serves as the System Manager; the other three companies have 8 percent, 3.41 percent and 2.3 percent ownership interests, respectively.

To assure continuity of maritime satellite communications services, COMSAT started planning for the second generation of satellites three years ago. Other efforts were also underway in various international bodies. These efforts have now culminated in the establishment of a new international organization, the International Maritime Satellite Organization (INMARSAT), which will come into being on July 16, 1979. On that date, the INMARSAT agreements, the negotiation of which was completed in the fall of 1976, will become effective.

In October 1978, the Congress passed legislation designating Comsat as the U.S. participant in INMARSAT, a role comparable to that given Comsat in INTELSAT under the Communications Satellite Act of 1962. Your Committee played an important role in the 1978 legislation, and we appreciate this expression of confidence in Comsat. We intend to do everything in our power to assure the success of our mandate and to justify that confidence.

What has MARISAT done for the merchant seamen? The uncertainties associated with long-standing, traditional maritime telecommunications techniques have been dramatically alleviated by quick and dependable satellite services.

The long delays encountered in communications between shore and ships, caused by atmospheric disturbances and the resulting uncertainties of high frequency radio signal propagation, is a thing of the past for those ships equipped with communications terminals capable of utilizing the MARISAT System. Essentially worldwide coverage has been available since November 1978 when Indian Ocean service was inaugurated. The number of vessels equipped with satellite terminals is now approximately 200 and growing continuously. Applications for service for about 30 more terminals are currently in process in COMSAT General.

Even before the MARISAT System became operational, the effectiveness of satellites of provide prompt and reliable communications services for health and safety purposes in remote locations was established. In an experimental program undertaken in 1973, Comsat and Project Hope conducted an exchange of medical data between various points in the United States and the medical ship, "SS Hope", docked in a Brazilian port, utilizing the INTELSAT satellite system. In fact, the ship had just arrived at its dock when the Hope's medical staff was faced with the need to perform corrective surgery for a detached retina. The patient was a member of the ship's administrative staff. The Hope's opthalmologist diagnosed the problem, then conferred via satellite with eye specialists in the United States. Diagrams of the damaged eye were transmitted via satellite to specialists in Atlanta, Georgia. After reviewing the graphic presentation of the problem and after further discussion with the Hope's medical staff, the decision was made to fly an eye surgeon and his colleague to the ship to perform the delicate operation. The three and one-half hour operation was successful and the patient has normal use of the eye.

Numerous examples have been reported to us since the inception of MARISAT operations on how the availability of maritime satellite services has resulted in life-saving aid to a stricken seaman at sea. Crucial time has been saved in obtaining proper medical advice not otherwise available from onboard ship resources.

I should like to mention briefly three specific arrangements that have been developed which will be of great benefit to seamen. In 1977 the U.S. Coast Guard instituted a MARISAT "Distress Hotline" which allows merchant vessels equipped with MARISAT terminals to report distress information directly to each Coast Guard Area Rescue Coordination Center.

In March 1978, COMSAT General entered into an agreement with the U.S. Coast Guard to provide medical service via the MARISAT system. Although such services are also provided through coast stations operating in the MF and HF frequency bands, the advantages of being able to use satellites were clearly recognized. The feasibility and procedures for providing a direct medical service were explored and an agreement was reached which permits direct access to the New York and San Francisco Centers for ships equipped for MARISAT service.

Most recently in January 1979, COMSAT General and the U.S. Coast Guard entered into another agreement under which ships may provide routing information to each Center via telex free of charge using MARISAT. Through the use of a computer, the Centers in New York and San Francisco keep contact with participating ships from the time of their departure from port until arrival at their destination. If a ship needs assistance, such as medical advice for ship personnel, the Coast Guard is able to query the computer immediately to determine the location of nearby ships and, thus, facilitate more rapid rescue or assistance. This system, known as AMVER, has been in operation since 1958, but now with the inclusion of ships with MARISAT terminals a more immediate and direct means for providing such assistance has become available.

Although there can be no doubt that satellite communications can and will assist in improving the safety of life at sea and, in particular, contribute significantly to the welfare of seamen aboard ships, the costs associated with equipping ships to use such satellite services does represent a problem of some magnitude. Traditionally, in the United States, communications services have been provided by the private sector on a commercial basis. This means that someone must bear the cost of providing the services involved. A determination by a ship owner regarding the cost/benefit impact on his operation resulting from the introduction of satellite communications is, in itself, a complex problem. One important aspect of such a determination is how best to meet the health and safety needs of seamen.

We in Comsat and COMSAT General are vitally interested in expanding the uses of satellite communications services so that costs may be reduced. We believe that we are making significant strides in persuading potential users of the diversity of benefits to be derived from sharply improved communications services. The role of the public sector in accelerating the use of this technology, as well as the relative responsibilities among the Government, users and providers of communications services, is a subject of concern to your Committee.

What can we expect from INMARSAT? When the international plenipotentiary conference completed the negotiation of the INMARSAT agreements in 1976, it also created a Preparatory Committee to expedite the effective functioning of INMARSAT once it came into being. The Committee began its work in January, 1977 and included in its late 1978 interim report to governments that participated in negotiating the INMARSAT agreements, the following views on distress capabilities:

"The capability to handle priority traffic through the INMARSAT space segment must be provided . . . The INMARSAT System should be designed to provide such a grade of public correspondence service that the volume of traffic can be handled with little or no delays involved. This means that distress/urgency/safety traffic should normally be handled by using the high-quality communication service which will be made available on board ships equipped with satellite terminals . . . The capability to pre-empt working channels for priority traffic, at such times as there is no idle channel available, should be provided."

I do not believe there is any question in anyone's mind about the potential value of improved communications services through the use of satellites for the social, mental and physical well-being of seamen. Our efforts must be directed at solving the most difficult question of how the cost of such services is to be borne. Comsat and COMSAT General have been very concerned about this problem and we are continually seeking ways to assure maximum availability of effective satellite services at the least cost. We are prepared to work closely with the Government and with shipowners in this task.

Mr. MARTIN. The improvement in communications with vessels on the high seas has been a matter of great interest to Comsat and its subsidiary, Comsat General, for several years. As I think this committee is aware, we began intensive efforts in 1973 that led to the first satellite system devoted to maritime telecommunications service, the Marisat system, which was brought into service in 1976.

That system, incidentally, Mr. Chairman, is reaching its third anniversary, and we have had the service available on a commercial basis now for almost 3 years. We feel fortunate to have had the opportunity to develop this improvement in communications which has important implications for the health and safety of merchant seamen worldwide.

I would like to review quickly, the background and current status of the maritime communications services, and make reference to some of the benefits which we think derive from this new service to the health and welfare of seamen.

Back in 1973, Comsat submitted a proposal and was awarded a contract to provide satellite communications services to the U.S. Navy. The satellite selected to provide the Navy service had sufficient weight and power capability to permit the incorporation of additional equipment for the simultaneous provision of commercial maritime services. A suitable communications system was designed and developed on an expedited basis and actual commercial service was introduced in mid-1976 in the Atlantic and Pacific Ocean regions. This new service provided for the first time, high quality, essentially undelayed telephone and telex contact between shore points and vessels, including a special arrangement that had been incorporated for distress priority calls.

To assure continuity of maritime satellite communications services, Comsat started planning for the second generation of satellites 3 years ago. Other efforts were also underway in various international bodies. These efforts have now culminated in the establishment of a new international organization, the International Maritime Satellite Organization—Inmarsat—which will come into being on July 16, 1979.

In October 1978, the Congress passed legislation designating Comsat as the U.S. participant in Inmarsat, a role comparable to that given Comsat in Intelsat under the Communications Satellite Act of 1962. We appreciate this expression of confidence in Comsat. We intend to do everything in our power to assure the success of our mandate and to justify that confidence.

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Even before the Marisat system became operational, the effectiveness of satellites to provide prompt and reliable communications services for health and safety purposes in remote locations was established. In an experimental program undertaken in 1973, Comsat and Project Hope conducted an exchange of medical data between various points in the United States and the medical ship, SS *Hope*, docked in a Brazilian port, utilizing the Intelsat satellite system.

In fact, the ship had just arrived at its dock when the *Hope's* medical staff was faced with the need to perform corrective surgery for a detached retina. The patient was a member of the ship's administrative staff. The *Hope's* opthalmologist diagnosed the problem, then conferred via satellite with eye specialists in the United States. Diagrams of the damaged eye were transmitted via satellite to specialists in Atlanta, Ga. After reviewing the graphic presentation of the problem, and after further discussion with the *Hope's* medical staff, the decision was made to fly an eye surgeon and his colleague to the ship to perform the delicate operation. The 3½-hour operation was successful and the patient has normal use of the eye.

Numerous examples have been reported to us since the inception of Marisat operations on how the availability of maritime satellite services has resulted in life-saving aid to a stricken seaman at sea. Crucial time has been saved in obtaining proper medical advice not otherwise available from onboard ship resources.

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In March of last year, Comsat General entered into an agreement with the U.S. Coast Guard to provide medical service via the Marisat system. Although such services are also provided through coast stations operating in the MF and HF frequency bands, the advantages of being able to use satellites were clearly recognized. The feasibility and procedures for providing a direct medical service were explored and an agreement was reached which permits direct access to the New York and San Francisco centers for ships equipped with Marisat service.

Most recently, in January of this year, Comsat General and the U.S. Coast Guard entered into another agreement under which ships may provide routing information to each center via telex, free of charge using Marisat. Through the use of a computer, the centers in New York and San Francisco keep contact with participating ships from the time of their departure from port until arrival at their destination. If a ship needs assistance, such as medical advice for ship personnel, the Coast Guard is able to query the computer immediately to determine the location of nearby ships and, thus, facilitate more rapid rescue or assistance. This system, known as Amver, has been in operation since 1958, but now with the inclusion of ships with Marisat terminals, a more immediate and direct means for providing such assistance has become available.

Although there can be no doubt that satellite communications can and will assist in improving the safety of life at sea and, in particular, contribute significantly to the welfare of seamen aboard ships, the costs associated with equipping ships to use such satellite services does represent a problem of some magnitude. Traditionally, in the United States, communications services have been provided by the private sector on a commercial basis. This means that someone must bear the cost of providing the services involved. A determination by a shipowner regarding the cost-benefit impact on his operations resulting from the introduction of satellite communications is, in itself, a complex problem. One important aspect of such a determination is how best to meet the health and safety needs of seamen.

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What can we expect from Inmarsat? When the International Plenipotentiary Conference completed the negotiation of the Inmarsat agreements in 1976, it also created a preparatory committee to expedite the effective functioning of Inmarsat, once it came into being. The committee began its work in January 1977, and included in its late 1978 interim report to governments that participated in negotiating the Inmarsat agreements, the following views on distress capabilities:

> The capability to handle priority traffic through the INMARSAT space segment must be provided—the INMARSAT System should be designed to provide such a grade of public correspondence service that the volume of traffic can be handled with little or no delays involved.

I might add parenthetically, Mr. Chairman, that these objectives stated for the Inmarsat system have been incorporated into the IMCO system today.

I do not believe there is any question in anyone's mind about the potential value of improved communications services through the use of satellites for the social, mental, and physical well-being of seamen. Our efforts must be directed at solving the most difficult question of how the cost of such services is to be borne. Comsat and Comsat General have been very concerned about this problem, and we are continually seeking ways to assure maximum availability of effective satellite services at the least cost. We are not only prepared, but anxious, to work closely with the Government and with the shipowners in this task.

Thank you, Mr. Chairman.

Mr. de la Garza. Thank you very much.

Any questions, counsel?

Mr. Seifert. Yes, Mr. Chairman, thank you.

I will address this to the panel generally.

There are 200 terminals, and about a third of them are U.S. applied. There is also the statement that Mr. Pitkin made, or two statements, one from domestic offshore operators, and one by an international container line, saying it would be more feasible for the other guy to do it. Sort of washing out both points of view.

What classes of vessels are equipped with these?

Mr. Martin. Well, we have a large number of files of vessels. I might just give you a quick rundown on the major types. Cargo containerships, there are over 30 equipped for this service, construction vessels, LNG tankers, oil drilling platforms, over 40 oil tankers, passenger hotel ships, seismic ships, there are a number of U.S. Government-owned vessels, including three Coast Guard vessels, and then a host of other vessels, yachts, research vessels, fishing vessels.

Mr. Seifert. So you could not say one type has dominated?

Mr. Martin. It covers the industry.

Mr. Seifert. What would be the cost of this? We talked about high cost, how much does it cost to install one of these terminals?

Mr. Martin. The terminals are available from a number of the manufacturers, and sources, to the shipowners, although as of this point in time, about two-thirds of the fleet are using terminals made available to them by purchase, or lease from Comsat General. That terminal is being sold at a price, I believe now, close to $62,000. For the monthly lease rate, I believe it costs between $1,500 and $2,000/month.

Mr. Seifert. Most high technology vessels now cost about $80 million, is that correct?

Mr. Pitkin. It varies, but that is a figure for some.

Mr. Seifert. Do you have any difficulty in communicating via satellite, some of the data between the vessel and the shore base itself?

Dr. Walsh. No, we did not. Comsat and ourselves were surprised to the degree of material that you could transmit. We were able to diagnose such things as leukemia via satellite, which they did not believe we could do. You could transmit breath sounds, which you could hear by satellite, hear well enough to make a diagnosis, and do not forget, as I said earlier, this was in a primitive stage, this was in 1973.

Now, you could transmit an amazing amount of material.

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Mr. **Seifert**. Are there any risks of priority traffic bumping the communication of medical information? Anybody? Say an SOS, navigational problem?

Mr. **Martin**. An SOS would preempt, if necessary, a channel. The distress system is such that if distress priority requests come from a vessel, and if all channels are occupied, then the distress call would seize a channel. But with the high speed, and the quality to date, I am not aware of any instance in which we have had a problem of conflicting traffic.

We would be pleased to fill up the existing channels.

Mr. **Seifert**. Are there any funding programs available to MarAd, which could be used to assist vessel operators in placing the $60,000 plus equipment aboard their vessel? What would be the arrangement for that supplemental addition?

Mr. **Pitkin**. I do not think at this moment there are. On new ships, possibly.

Mr. **Seifert**. I am talking about existing vessels.

Mr. **Pitkin**. No, this issue, I believe, had been raised, and the conclusion was that the addition of that equipment would not qualify for subsidy funds.

Mr. **Seifert**. Is that given the state of the law right now?

Mr. **Pitkin**. Yes.

Mr. **Seifert**. You have not, to your knowledge, that is MarAd, has not submitted any legislative proposals for us to consider?

Mr. **Pitkin**. To my knowledge, no such legislation has been proposed.

Mr. **Seifert**. Is there any possibility that it will be proposed, based upon the type of hearings we have undertaken so far in the last few days?

Mr. **Pitkin**. I am sure the interest of the community in this respect is the Maritime Administration, and I will be happy to discuss it further.

Mr. **Seifert**. Is there any risk that spurious signals might make unreliable transmissions of analog data. Seeing as you are not dealing with voice, there is no way to confirm what the person said. Would there be any risk of that being garbled, in any way, without checking it?

Mr. **Martin**. In the current system, the method for transmitting data is one of the voice channels, and to date, both in our operational experience, and in test programs which we have conducted separate from the operational service, we found a very high degree of reliability, and no indications of interferrence, even when operating, where we had been concerned about that possibility.

Mr. **Seifert**. I have no further questions, Mr. Chairman.

Mr. **de la Garza**. Mr. Bruce?

Mr. **Bruce**. Just a couple of questions.

I am a little concerned about the North Shore Hospital proposal in 1977 which, as I understand, if you progressed to a fully operational stage, was to provide medical information?

Mr. **Pitkin**. They proposed to us their facility as a demonstration project, to demonstrate the suitability of their program. We do not, under our charter, have the authority to set up such centers. They are the Public Health Service's responsibility, of course. But North Shore was proposing a demonstration to the Maritime.

Mr. **Bruce**. You have already answered my next questions. That 637, was that done on a cost-shared basis?

Mr. **Pitkin**. No, that was part of the problem.

Mr. **Bruce**. Assuming North Shore was set up, was industry expected to cooperate in a sharing of funding for that center in any way?

Mr. **Pitkin**. Well, we lack the authority to fund the center ourselves. We can do the promotional work, or the research and development work, which leads to the ascertainment of its merits, but the actual operation, of course, is a commercial responsibility, and would normally, in my opinion, be assumed by the industry.

Mr. **Bruce**. I have a question for Mr. Martin. It is a followup question on my question to Admiral Bell.

But in the cases you have cited, it appeared to me that there was direct linkage between the concurring physicians. There was direct communication. No third party intermediary. You cite the capability of the Coast Guard, of their terminals in New York and San Francisco, and cite the agreement between you.

What is the linkage between those facilities and terminals, and the nearest Public Health Service Hospital facility?

Mr. **Martin**. First of all, I would like to distinguish between the experiment with the U.S.S. *Hope*, which was 3 years in advance of the system, that was a special arrangement with Project Hope, and not part of the operational system. So the arrangement for direct medical contacts were set up in advance as part of a test program, and not a real emergency.

In the commercial system, the Marisat system now in existence, what we have is a direct connection between our shore stations and the Coast Guard center, and what the Coast Guard does from its Center outward is something I think that the Coast Guard would have to address. I frankly cannot answer that question.

Mr. **Bruce**. Have you explored the possibility of linking your station to the nearest hospital, or is that something that is beyond the realm of the capability because of commercial nature of your activities?

Mr. **Martin**. We are basically capable of providing our service, which is the real nature of your question, to anyone who wants it. If it is through terrestrial interconnection in the United States we can reach any hospital, any home, any Government agency, any private entity, or whatever, from our shore stations. It is simply a matter of the requirement of service being stated to the providers. They will provide it.

Mr. **Bruce**. So the capability exists to establish communication directly from the person in need with the facility providing the information?

Mr. **Martin**. Yes.

Mr. **Seifert**. What is the cost of a land station? You are not talking about a land station, you are talking about running land lines from your shore based receiver to whatever hospital or medical facility we are talking about.

Mr. **Martin**. That is correct. The cost of a shore station, I would have to simply estimate at this point in time, but approaching $5 million. So it tends to make more sense to use the high quality terrestrial network that we have already developed within the country to move traffic.

Mr. **Seifert**. Thank you.

Mr. **de la Garza**. Thank you, gentlemen. I appreciate your presence.

The next panel will be composed of Mr. Burt Lanpher, Mr. Ed Kelly, Mr. Earl Clark, and Capt. Robert Lowen.

If you gentlemen will proceed in the order that you appear on the witness list. First would be Mr. Lanpher.

STATEMENTS OF PANEL CONSISTING OF BURT E. LANPHER, SECRETARY-TREASURER, STAFF OFFICERS ASSOCIATION OF AMERICA, ACCOMPANIED BY JOSEPH W. RUGENIS, PURSER-MARINE PHYSICIAN ASSISTANT, MAX CONDIOTTI, ADMINISTRATOR OF THE STAFF OFFICERS ASSOCIATION, MARINE PHYSICIAN ASSISTANTS PROGRAM; ED KELLY, MARINE ENGINEERS BENEFICIAL ASSOCIATION; EARL CLARKE, CO-DIRECTOR, LABOR-MANAGEMENT MARITIME COMMITTEE; AND CAPT. ROBERT LOWEN, PRESIDENT, MASTERS, MATES & PILOTS INTERNATIONAL

Mr. **Lanpher**. Thank you, Mr. Chairman.

First, before I start my testimony, I would like to introduce my colleagues who are here. Mr. Joseph W. Rugenis, on my far right, is a purser-marine physician assistant. He is a graduate of the Staff Officers Association Marine Physician Assistant Program, and he is employed on cargo ships of the United States Lines, Inc.

Next to me is Max Condiotti, who is the administrator of the Staff Officers Association Marine Physician Assistant Program, and he is also a graduate of the marine physician assistants program.

Mr. **de la Garza**. Thank you, sir.

We welcome both of these gentlemen.

Mr. **Lanpher**. Mr. Chairman and members of the Committee on Merchant Marine, my name is Burt E. Lanpher. I am the secretary-treasurer and chief executive officer of the Staff Officers Association of America, which is a maritime labor organization with headquarters in Hoboken, N.J. Our organization is an autonomous union affiliated with the Seafarers International Union of North America, AFL–CIO, of which I am a vice president.

The Staff Officers Association represents purser-marine physician assistants and other purser personnel who serve in independent medical duty status aboard various vessels of the U.S. merchant marine.

Purser personnel are recognized as staff officers as designated by the Staff Officers Act of 1939. Our members perform routine and emergency medical work, as well as administrative, payroll, and documentary work relating to the ship's business at sea and in ports throughout the world.

They act as an extension of the U.S. Public Health Service aboard merchant vessels at sea to render medical care to seamen.

As a result, our organization has long been the prime mover in the United States and abroad for improved standards and a more professional level of medical care aboard ship.

We therefore welcome the inquiry which the committee is undertaking at the present time into the medical care aspects of life at sea, and the role of the U.S. Public Health Service Hospitals in improving the quality of medical care for merchant seamen.

We look forward to a prompt resolution of your examination into this subject, which deals with matters of life, health, and safety, because there is so much that can be done.

Ten years ago, in May 1969, a distinguished panel of physicians stated:

> The lack of adequate medical care aboard ship is deplorable * * * formal standards of health care are virtually nonexistent and medical services are woefully inadequate aboard ship * * * we must be certain that the health of this small but vital group of citizens is no longer neglected.

This panel, which was conducting an evaluation of the SOA training program for marine physician assistants, highly commended the SOA and the USPHS—

> For their foresight in planning and diligence in developing and implementing this program. In addition to fulfilling the specific need of improving the lot of the American seaman, it affords to the rest of the nation a prototype from which other courses will evolve.

Unfortunately, although our program did serve as a valuable prototype for others, the state of medical care at sea today is still bleak for seamen.

With the conspicuous exception of less than 100 vessels which carry a purser-marine physician assistant, purser-pharmacist mate or their equivalent in training and capability, medical care on all other U.S. merchant vessels is largely nonexistent.

A limited first aid capacity continues to be the only level of care immediately available on most American-flag vessels, unlike the situation that prevails in the fleets of many less-developed nations.

Thus, the chances are good that, at this very moment, somewhere, an American seaman lies painfully injured or seriously ill aboard an American merchant ship without adequate medical help at his side. Before he receives proper care, his injury or illness may worsen, his general health may decline and, if he survives, he risks permanent impairment of bodily functions.

In an era of technical sophistication and technological advance that has revolutionized merchant shipping, this little-noticed folly is a national disgrace. It imposes unnecessary suffering, hardship, and cost, often at the expense of the American taxpayer.

According to the Marine Index Bureau, Inc., a reporting service that gathers reports of illnesses and injuries among seafaring personnel, over 74 illnesses and/or injuries were reported in 1978 for every 100 jobs in the U.S.-flag deep sea fleet. In fact, an examination of the Marine Index Bureau figures, based on data submitted by operators of U.S. oceangoing vessels, reveals an illness/injury incidence of 73.2 for the past 10 years for every 100 jobs in the U.S.-flag deep sea fleet.

The implication of these figures for U.S. maritime is clear.

Some means must be found to end the isolation of American seamen from proper medical care when they need it most.

Sadly, unless there is a marine physician assistant available, the quality of our shipboard medicine lags behind all of our other advances. In reality, since few ships have doctors and barely 1 in 8 carries a qualified marine physician assistant, our seamen must gamble as they have for centuries past and hope to suffer nothing worse than simple injuries or an ailment requiring basic first aid treatment only.

The only on-the-spot medical care immediately available on most vessels depends on personnel charged with other essential duties and responsibilities, especially in emergencies and on the limited first aid training they may have received many years before, without benefit of a refresher course.

The sickness or accident victim on our ships at sea is literally at the mercy of doctoring and medical assistance by remote control, since sea and air rescues in mid-ocean are not always feasible.

He must rely on someone who is totally inexperienced and can second-guess the symptoms described in a medical manual, the ship's medicine chest, or information sought by radio from a distant shore station. Of course, this also presumes a capability to transmit, receive, and carry out radio medical advice which may be highly technical, with regard to preserving life and limb.

Ironically, the victim's best hope is that a more adequately-staffed foreign vessel is passing nearby, since many countries provide more extensive medical care than is required by the United States. These nations have seen that the efficiency and profitability of their fleets depends greatly on the physical fitness of their crews. They have reached a judgment which is difficult to dispute, as their fleets grow and surpass our own.

From any standpoint, this is not a satisfactory situation. No group should be treated as second-class citizens, nor should they be subjected to inferior, makeshift medical care arrangements, merely because their working place and living environment is aboard an American ship at sea.

U.S. merchant seamen are a uniquely-situated group of workers. Due to the nature of their employment and their working place, they are deprived of prompt, proper medical care when they may need it most.

The concept of the purser-marine physician assistant, earlier known as the purser-pharmacist mate, was pioneered by the SOA to fill this need, as medical costs, insurance claims and shipping delays directly traceable to the void in shipboard medical care increasingly plagued the American fleet in the 1960's.

It then took 4 years of persistence, negotiation, meetings and haggling involving the union, the shipping companies, and several Government agencies before the first class of trainees began in 1966.

Given versatility and enhanced skills, these personnel have been trained for up to a full year of 2,080 hours by the U.S. Public Health Service in didactic, practical and clinical medical work, or by the various armed services. They qualified to provide a professional level of medical care far in excess of a simple first aid capacity, and they have performed this function in all types of emergencies.

In addition, they function at all times as the ship's administrative officer and as an extension of the company office aboard ship.

The medical training enables the purser-marine physician assistant to function independently at sea and to obtain and carry out radio instructions from shoreside doctors. But the program carefully observes the distinctions which must be drawn between medical practice, as a physician, and vocational training for seagoing personnel in the field of medicine and first aid.

Even if humanitarian considerations were not compelling, the program has made sense from a cost standpoint alone. Savings have been realized through reduction in shipboard medical work, by reduction in lost time due to hospitalization, decrease in insurance costs, reduction in medical claims filed for personal injury, and cuts in costly repatriation and travel expense to replace personnel in faraway ports.

This is not the first time that shipboard medical care was provided for the American merchant fleet. During World War II, the Federal Government instituted a 4-month purser-pharmacist mate training program to maintain the physical fitness of the crews. After the war, these schools closed, and attrition decimated the ranks of those who had graduated as pharmacist mates, but it is interesting to note that no less than a 4-month program was considered adequate over three decades ago and in wartime.

Nevertheless, despite the emergence of the purser-marine physician assistant as a viable officer rating, with the decline present in U.S. merchant shipping, personnel cutbacks have been necessitated, and no additional shipping companies have employed these personnel.

The result leaves our merchant fleet largely without the help and service of the marine physician assistant which the USPHS 10 years ago characterized as:

> * * * an integral link in the chain of patient care for the seamen of the merchant fleet * * * an arm of the physician * * * (and) * * * the minimum acceptable level of medical care for the merchant mariner when at sea.

We believe that this promise can and must be brought to a reality. The crippling inertia in the industry must be overcome. It can be done by changing the present statutory situation which has kept U.S. merchant seamen in a "no man's land" without escape.

None of the Federal agencies with primary responsibilities in the maritime field accepts the duty to require and assure prompt proper medical care for seamen on American vessels.

The Department of Commerce, and its subordinate agency, the Maritime Administration, do not impose a responsibility on U.S. shipowners to provide any form of prompt proper medical care at sea for American merchant seamen. Our laws impose such a responsibility on a shipowner only in instances when more than 12 passengers are carried.

Beyond this requirement, which operates only when a specified number of passengers are carried, the Maritime Administration has passed over its obligation in this area.

The duty of the United States to provide for the health and medical care of merchant seamen has been recognized since 1798, when the U.S. Public Health Service and its essential network of marine hospitals and clinics originated. This responsibility is presumed to end at the water's edge by the Department of Health, Education, and Welfare and by the U.S. Public Health Service, which is the subordinate agency of HEW that operates directly in the maritime field.

The U.S. Coast Guard, which is under the jurisdiction of the Department of Transportation, carries out the navigation laws of the United States, and the obligations of the United States in the world community with respect to the preservation of the health and safety of life at sea.

The navigation laws require a vessel to carry a medicine chest, but are unresponsive in specifying its size, the nature of its contents, their quality, or the means by which medicines are to be administered or replenished.

As part of its function in licensing and certificating ship personnel, the Coast Guard requires applicants for original licenses to present a first aid certificate.

The Coast Guard and the Department of Transportation disclaim any further responsibility to insure the availability of primary medical care for seamen on American merchant vessels.

Mr. Chairman, I would like to add something to my testimony at this time, if I may, with your permission.

Mr. LOWRY [presiding]. Yes?

Mr. LANPHER. We are pleased to welcome the expression by the Coast Guard today on proposed standards for health care personnel in our merchant vessels. However, again the proposal for grade 3 level of training, merchant vessels, ocean voyages, completely overlooks the needs of seamen. The Coast Guard presentation proposing 240 hours of training for seamen on cargo vessels shows a preoccupation with color coding and not with seamen's health. Since passenger ships carry doctors, then grade 4 should be the standard for oceangoing freight vessels.

Ironically, on its own vessels, the Coast Guard requires the presence of personnel who can provide medical care at various professional levels.

In addition to the situation cited above with regard to the various Federal agencies and departments which exercise some measure of jurisdiction in the maritime field, seamen are specifically excluded from the protection of the Occupational Safety and Health Act—OSHA—although they are employed in what is recognized as one of the most hazardous of all occupations and professions.

The existence of a special admiralty jurisdiction is firmly established and well-recognized in American law, with regard to the ship, its cargo, and its personnel.

U.S. courts and the State courts have traditionally regarded seamen as "wards of the court," as a group whose generally transient living conditions ashore and whose service in the commerce of the United States, with its attendant potential for peril to the health and well-being of the public, requires special attention.

Indeed, such was the rationale for the establishment of the U.S. Public Health Service and its marine facilities in the early days of our nation.

As ably stated by Justice Cardozo in one of our landmark maritime cases, the unchanged situation, even today, comes down to this, and I quote:

> The seaman deprived of proper medical care suffers a 'personal injury' quite as much as the sailor who falls from a defective rigging. (*Cortes* v. *Baltimore Insular Lines*, 287 U.S. 367.)

Further, American courts have imposed upon the shipowner a responsibility for failure to treat, as well as the duty of reasonable care.

An additional responsibility arises from the doctrine of seaworthiness and the obligation to furnish a safe and seaworthy vessel.

The shipowner's duty is not only to pay for the seaman's maintenance and cure but to take all reasonable steps to make sure that the seaman, when he is injured or becomes sick, receives proper care and treatment. If proper treatment is not available aboard ship, it is the master's duty to put into the nearest available port where the treatment can be obtained.

If the master or owner fails to provide proper care and, as a result, the seaman's condition is aggravated, the shipowner is liable not only for the increased medical expenses and maintenance that may become necessary, but also for the resulting damages.

In sum, there is an abundance of case law on the general subject of medical care and a tendency to large entitlements in maritime cases.

The anomaly in our industry is that in the face of all this, a higher level of shipboard medical care is not demanded and mandated. But the market forces that operate in the maritime field have always behaved strangely.

We believe that the Committee on Merchant Marine and Fisheries is best equipped to alert the Congress and to focus the attention of the American public on the medical care situation which affects the lives and the livelihood of every merchant seaman. Historically, the Congress has enacted legislation to protect the rights of seamen, and to extend the same kinds of benefits and rights which accrue to citizens and workers ashore.

It is time to do so again.

At the outset, we urge rejection of any concept of shipboard medical care based on short-term training at the first aid level. Such limits pose serious dangers to life and safety when sickness and accident occur and are untended by medically-qualified personnel for long periods of time.

In international forums and here in the United States, the SOA has recommended establishment of a reasonable minimum standard of training and practice for officers responsible for medical care aboard ship as part of their regular duties.

To carry out this objective, we have proposed a training curriculum which provides the means to achieve increased levels of safety and crew efficiency by establishing 2,000 hours of paramedical training and instruction as the minimum qualification for certification in paramedical training.

The SOA has further recommended that all oceangoing vessels of 10,000 gross tons and above which do not carry a doctor shall carry at least one officer whose qualifications include certification in paramedical training as prescribed in the training curriculum.

Such a minimum assures a practical and cost-effective means to remedy the isolated condition of ships at sea which often deprives seafarers of adequate medical care and attention when they need it most. Inasmuch as a 2,000-hour minimum is under consideration as a standard on an international level for ships of all nations, we believe the United States should do no less for its own ship personnel.

We continue to reject any notion that short-term programs as instituted by various organizations to acquaint their members with first aid and medical techniques are a substitute for the minimal 2,000 hours of training and comprehension which can adequately prepare personnel for service in independent medical duty status.

We recall again the 4-month crash program which existed in World War II for purser-pharmacist mates. Moreover, with the assistance of the USPHS Hospital, Staten Island, N.Y., where our original training program originated in 1966, we have developed a 6-week review course for marine physician assistants which shall begin in October of this year.

The 6-week review, it must be pointed out, is regarded as the absolute minimum for a successful review program. Accordingly, it is difficult to contemplate how any 10-day, 30-day or 60-day sequence of original training, can produce the same result as a 2,000-hour curriculum.

We regard such short-term instruction as useful and meaningful only if the practitioner thereof is not the sole medical support personnel on the vessel.

Seeking means to provide better delivery of health services and emergency medical care to American seamen, we also have proposed to undertake a project which would demonstrate the efficacy of a satellite communications system in upgrading the quality of medical care currently available on American-flag vessels.

This project will be known as the shipboard medical satellite communications project, MEDSHIP, and involves the active participation of the USPHS Hospital, Staten Island. We believe that it merits the support of the Maritime Administration and are continuing to press for its assistance.

MEDSHIP would utilize existing satellite communications technology, qualified Marine Physician Assistants presently sailing and the medical expertise of the Staten Island Hospital to manage shipboard illnesses and injuries. A study conducted under the auspices of the National Maritime Research Center has documented the need for and feasibility of developing and using a satellite communications system, and outlined guidelines for conducting a demonstration. Every corpsman, and this is additional——

Mr. **Lowry**. I wonder if I can interrupt one moment.

I have 5 minutes to run over and vote on the Department of Agriculture budget. I would like to suggest that we recess until 1 o'clock, which will give people a chance to get a cup of coffee or a sandwich, and then we will return at 1 o'clock.

I am sorry to have to do this but there is a vote going on on the floor.

Mr. **Lanpher**. I only have two more pages.

Mr. **Lowry**. But I will miss the vote. I have 4 minutes to get to the House floor.

Thank you very much, and I apologize for interrupting your very meaningful statement.

We will be in recess until 1 o'clock. Thank you.

[Whereupon, at 12:30 p.m., the committee recessed, to reconvene at 1 p.m., the same day.]

AFTERNOON SESSION

The **Chairman** [presiding]. Mr. Lanpher, you may finish up.

Mr. **Lanpher**. Yes, Mr. Chairman.

Before I resume my testimony, I would like to add some testimony at this point, if I may, with your permission.

The **Chairman**. Without objection.

Mr. **Lanpher**. Thank you, Mr. Chairman.

Every comment that has been made here today by others on the medical satellite system assumes the absence of a trained, medically qualified person on the vessel.

Now, the program that I have just outlined, utilizing the dual-skilled rating of the purser, meets this need. Further, it is clear from the testimony so far today that the health of the seamen is a low-level concern, and that there is no willingness to recognize that in the 1980's we should be further advanced than we were in 1880 or 100 years earlier. Also may I propose another acronym? The word is SEASICK, which is what I am as I have listened to so many roundabout, evasive means to provide adequate shipboard health care, when the answer is so clear. The answer it to expand the standards that are now in effect on 20 percent of U. S, merchant marine vessels to improve the substandards now in effect on the other 80 percent. The best solutions are usually the simplest.

We note also what appears to be a lack of high-level consultation by the Coast Guard and the USPHS on questions of seamen's health care.

Back on my testimony, Mr. Chairman.

The participation of the USPHS Hospital, Staten Island, makes it possible to elaborate on these proposals, to design and conduct an appropriate demonstration and, finally, to assess its utility and impact.

However, although the shipboard components and technology already exist on large numbers of vessels, we have been told by MarAd that the proposal is too technical.

The consequences of this kind of drift and defeatism as we approach the 1980's can best be gaged by the report from the Marine Index Bureau previously mentioned. If there are presently 73-plus reports of illnesses and injuries aboard our ships per 100 jobs, as our shipboard personnel is aging, what will the figure be a few years from now?

We believe that it is time now to stop treating seamen as second-class citizens–barring them from a proper level of medical care on their ships at the critical onset of illness and injury.

It is time to bring more and better medical care to seamen aboard their vessels, not to compound the medical neglect of the past. Medical care, in quality, can be available aboard every ship. The future of our merchant fleet lies not in retrenchment, but in the judicious expansion of vital services. The lack of proper medical care for our personnel can only hasten its demise.

Before we go into questions, Mr. Chairman, I would like to add to what I said when I introduced Mr. Rugenis this morning in the first part of the testimony. I would like to add that he was on a cargo vessel out in Vietnam, when they evacuated Saigon and took 6,000 Vietnam refugees to Guam, and you can imagine the difficulties on a cargo vessel with 45 in the crew by adding 6,000 to it. He was the medical officer aboard, with two Navy corpsmen, I think, to help him, and performed in an outstanding manner then as on other occasions. I also neglected to mention that he is the president of the Staff Officers Association, for the record.

Thank you, Mr. Chairman.

The Chairman. Thank you, Mr. Lanpher.

How much does this proposal add to the manning cost of the ship?

Mr. Lanpher. Well, Mr. Chairman, I really do not think it adds to the cost aboard the vessel. I think it saves in cost on the vessel because on the vessels where we do have the purser—Marine Physician Assistant, it has been shown that the medical claims are down, and that the work is being done properly, the administrative work, as well as the medical work. However, on the vessels that do not have such personnel aboard, we have some other person on the vessel, such the master, chief officer, or the chief steward doing this work, along with their other duties and, of course, they are certainly being paid extra for this and are not trained as well.

So I do not think there is a cost factor involved in it. Mr. Chairman, labor costs may have been a serious cost factor a few years ago, but the labor costs have turned around. The major cost in the operation of a vessel today is fuel costs, and maintenance, and repairs, not labor cost.

The Chairman. What countries have the superior service that you refer to on page 4?

Mr. Lanpher. The Eastern European countries and Japan, Russia has it, Bulgaria has it, Poland has it. They usually have a person aboard that vessel who has had over 2,000 hours of medical training. In Bulgaria, on their cargo vessels, they require that a medical student, in his third year, go to sea for 1 year on a cargo vessel. I know Japan has superior medical provisions; they usually have a purser who also does medical work. I do not know how much training they get, but I know they get more than the fellow in the United States.

The Chairman. Counsel?

Mr. Seifert. With the permission of the chairman, I would like to submit questions for the record, in the interest of time.

The Chairman. OK.

Mr. Ed Kelly.

Mr. Kelly. My name is Ed Kelly, and I represent district 2 MEBA-Associated Maritime Officers, AFL–CIO.

I submitted a copy of the statement to the committee and I would request that it be entered in its entirety into the record and I would like to summarize it without objection.

The Chairman. Without objection, it is so ordered.

[The following was received for the record:]

PREPARED STATEMENT OF ED KELLY, MARINE ENGINEERS BENEFICIAL ASSOCIATION

My name is Ed Kelly, and I represent District 2 Marine Engineers Beneficial Association-Associated Maritime Officers, AFL–CIO. I want to discuss District 2 MEBA-AMO's position in regard to shipboard health and working conditions on U.S.-flag Deep-Sea and Great Lakes merchant vessels.

Americans with shoreside jobs have available to them the highest standards in the world for medical care. This is as true on a casual level, if you stop in a pharmacy on the way home for tablets to ease a headache, as if you had a major medical problem, such as sudden pain in your chest or skull. If someone collapsed in this room, paramedics would arrive, and an ambulance would speed the victim to a hospital where the full resources of intensive care would be used in an attempt to save a life.

On U.S.-flag merchant ships, an officer or seaman can go to the Second Mate for pills to relieve a headache. With luck, that same Second Mate can administer morphine and set broken bones. But the number-one killer at sea, cardiac trauma, remains a formidable problem. In many cases of heart attacks, nothing can be done, in spite of the training of more U.S. officers and seamen in cardiopulmonary resuscitation, which can keep luckier victims alive for the hours until shore-based helicopters can reach the ship.

The statistics for illness at sea in 1978 indicate the potential health hazard ahead. During a year in which the number of jobs for Americans on U.S. ships fell to an all-time low of 20,500, there were 15,523 cases of illness or injury recorded in the U.S.-flag merchant marine. Two factors are of particular concern: the number of degenerative diseases, and the average age—40—of U.S. seafarers who fall prey to such illnesses, which include hypertension, strokes and heart disease, all made worse by conditions of high stress and physical exhaustion.

What conditions contribute to stress and exhaustion? Excessive noise and vibration on older vessels in the U.S.-flag merchant fleet. Inadequate air circulation and dubious insulation. With regard to the latter, District 2 MEBA-AMO is following with particular interest the Maritime Administration's current study of asbestos as a threat to health in the enginerooms of U.S. merchant vessels. On the Great Lakes, some companies have been lax in providing survival suits for seamen who work during the extended winter navigation season. Dockside hazards around the Lakes are common, ranging from casually hung boarding ladders instead of affixed gangways to inadequate lighting at night as ships unload taconite. Last year in Toledo, one of our members lost his legs when struck by a shuntling hopper car. He was on his way across unlit rail tracks to a phone booth nearby.

Working at sea is a dangerous profession. Our members live every day with the knowledge that a careless mistake can end their lives. Today, however, I am talking about that shadowy ambience of malaise that can extend over a vessel on which the crew has an excellent safety record. If food, sanitary conditions, or environmental tolerances in working areas dip below acceptable levels, and people become ill—whose fault is it?

Under the law, the U.S. Coast Guard is charged with the responsibility to see that U.S.-flag merchant vessels are operated according to mandated standards of health and safety. The Coast Guard's responsibility goes beyond whether the master obeys the Rules of the Road, or whether machinery on board is functioning properly. There is a human factor that, frankly, the Coast Guard has been remiss in handling adequately. Bad food, poor air, unsanitary conditions, an empty ship's medical chest—these are problems that too often the Coast Guard leaves to officers and seamen to talk to the operators about, thereby ducking the health issue—with the consequences indicated in the figures mentioned before.

District 2 MEBA-AMO feels that the U.S. Public Health Service Hospitals should create and promulgate a comprehensive health education program targeted to individuals working at sea, shaking them out of physical lassitude into a healthier frame of mind and state of body. Exercise and diet are as important as hygiene. Perhaps such a PHS program could be made part of the license upgrading classes at union schools. Hand in hand with this is the clear need for more U.S. seafarers to be trained as paramedics and provided with the equipment to sustain life during cardiac trauma. "Heart carts"—portable medical resuscitators—have come down in cost to where it is not unthinkable to have such devices on merchant vessels. If each ship, along with its television and washing machine, had a "heart cart" and crewmen trained in its use, then we would see a drop in the number of American seamen who die in the first hours after suffering heart attacks.

Other federal agencies that would normally concern themselves with health conditions in the merchant marine cannot, according to 29 U.S.C. 653, do so as long as the Coast Guard retains the authority to oversee such conditions, an authority that goes unused. In our opinion, the Coast Guard has been negligent of health concerns on U.S.-flag merchant ships to a point that cannot be tolerated any longer.

I thank you for your interest, because any beneficial change in the current state of affairs is likely to be at your direction.

Mr. Kelly. The No. 1 killer at sea, cardiac trauma, remains a problem. Nothing can be done despite the training of more U.S. officers and seamen in cardiopulmonary resuscitation so that helicopters can reach a ship.

But, this morning, the Coast Guard, Admiral Bell's statement, testified that in a 5-year period, 93 percent of the shipboard heart attack victims died. The death rate ashore is just 25 percent.

Under the law, the Coast Guard is charged with responsibility to see that U.S.-flag merchant vessels are operated according to mandated standards of health and safety. The Coast Guard's responsibility goes a long, whether the master obeys the rules of road or whether the machinery is operating properly.

There is a human factor that the Coast Guard missed in handling adequately. District 2 MEBA-AMO feels that the U.S. Public Health Service Hospitals should create and promulgate a comprehensive health education program integrated to individuals working at sea. Exercise and diet are as important as hygiene. Perhaps such a PHS program could be made part of the license upgrading classes at union schools. Hand in hand with this is the clear need for more U.S. seafarers to be trained as paramedics and provided with the equipment to sustain life during cardiac trauma. Heart carts, portable medical resuscitators, have come down in cost to where it is not unthinkable to have such devices on merchant vessels. If each ship, along with its television and washing machine, had a heart cart and crewmen trained in its use, then we would see a drop in the number of American seamen who die in the first hours after suffering heart attacks.

We want to thank the committee for its interest because any changes made in the current state of affairs will have to come from your direction. Thank you.

The CHAIRMAN. Thank you, Mr. Kelly.

You talk about cardiac trauma at sea as the No. 1 killer. Beside the conditions of high seas, perhaps fast physical exertion; does alcohol contribute to the development of heart disease at sea?

Mr. KELLY. I do not know. Dr. Erickson would be better able to answer that.

The CHAIRMAN. Is alcohol available on board ship?

Mr. KELLY. Yes, it is.

The CHAIRMAN. How much does a heart cart cost?

Mr. KELLY. I have no idea at the present time.

The CHAIRMAN. A course in cardiopulmonary resuscitation takes about 6 hours. Are you aware of how many men on board ship have taken this course and how extensive it has been?

Mr. KELLY. I know at the schools they are giving a course right now called Upgraders. I know the graduates of the various maritime academies have had that course, and I know that people have attended our upgrading school, district 2 upgrading school, and have had the same course. I cannot speak for them but I believe they all use the same course.

The CHAIRMAN. The desription of the working conditions aboard ship, noise, vibration, inadequate air circulation, it sounds like a Dickens novel. You point a finger at the Coast Guard for being remiss in their responsibilities.

Do the regulations need to be revised or merely enforced?

Mr. KELLY. I believe the regulations need to be enforced rather than revised. I think we should take a look at the regulations as they are presently laid out and have them enforced by the Coast Guard.

The **Chairman**. Mr. Bruce.

Mr. **Bruce**. Just two questions, sir.

Apparently labor-management negotiations, that type of process, has fallen down and not provided a solution to your problem.

To what extent do the insurance carriers or underwriters contribute to living conditions aboard ship? Or would you like to answer that for the record?

Mr. **Kelly**. I think I had better answer that for the record.

[The material was not received at time of printing.]

Mr. **Bruce**. I have one other question that seems to be at the root of some of the problems. Several people have cited an aging factor as one contributing to the problems that we are facing this day. What efforts or what headway is being made by the seafaring community to attract younger men and women into this industry, to jobs aboard ship?

Mr. **Kelly**. We are attracting them right now. They are coming into the industry. When our shipping is good, you are going to get younger men. If it is bad, then you are going to get the older ones. We take the various graduates of the academies as we can get when shipping is good. But when it is bad, we do not take as many.

Mr. **Bruce**. Is there any ratio of change of older men to younger men taking place now, for example?

Mr. **Kelly**. I think with shipping being good, you are seeing a change, you are seeing many younger men coming into the industry, particularly as third mates and third assistant engineers.

Mr. **Bruce**. Thank you.

The **Chairman**. Earl Clark.

Mr. **Clark**. Mr. Chairman, I would like to make just a few summary remarks and file our full report into the record.

The **Chairman**. Without objection, the full statement will be placed in the record.

[The following was received for the record.]

Prepared Statement of the Labor-Management Maritime Committee
Presented by Earl W. Clark

GENERAL COMMENTS

The Labor-Management Maritime Committee, composed of major steamship lines and maritime labor, presents this statement in connection with the oversight hearings on the Public Health Service Hospital program, conducted by the Subcommittee on Merchant Marine, of the House Committee on Merchant Marine and Fisheries.

The Labor-Management Maritime Committee has long supported the U.S. Public Health Service Hospital program, especially its care for merchant seamen, and recalls the efforts of the Executive branch of government in times past to diminish, if not even eliminate, the program. In each instance, it was the Congress of the United States that came to the defense of the program as in 1964, in 1971, in 1973, and at other times, culminating eventually in the passage of Public Law 93-155. This law requires the Administration to transmit to the Congress any proposal for either closure or transfer of any PHS Hospital for Congressional review within a given time frame before any action can be taken. This support of the Congress has been greatly appreciated by all those who support and highly value the effective work performed by the PHS over many decades of the past.

It is, therefore, a pleasant experience to note the positive recommendations of the Public Health Service Hospitals Ad Hoc Advisory Committee in giving continued support to the PHS Hospital program with proposals for even expanded services to meet the needs of eligible beneficiaries along with a closer tie to other community services.

In the case of merchant seamen, the Ad Hoc Committee observed past efforts to realistically assess options and alternatives to seamen's care and clearly found that the current direct delivery approach through the "use of PHS staff and facilities to provide primary and secondary (as distinct from tertiary) care is less costly than would be the purchase of services in the private sector." This fact has been attested to in several previous Congressional hearings on the subject and the Congress has undoubtedly taken this view into account. The Public Health Service Hospitals Ad Hoc Advisory Committee report particularly noted that "each time the direct delivery approach has been challenged, the Congress has reaffirmed both the commitment of service to the American seaman (and others), as well as the method of service." The report specifically referred to the Law of 1973 (P.L. 93-155) in which "Congress mandated the continued existence of the PHS Hospitals and the maintenance of the level and range of services at least as great as those provided or authorized at the beginning of that year." Finally, the committee reached the "conclusion that alternative cost effective means for government to carry out the responsibilities it has assumed are not readily available."

Having set forth these general comments, including some observations by the Ad Hoc Committee with which we concur, we turn to certain of the specific recommendations as they relate to seamen's health care. While we find no particular objection to the twelve recommendations set forth in the report, we shall address ourselves specifically to those having a more direct bearing on seamen's health care which is our primary point of interest.

HOSPITAL RETENTION AND EXPANSION

First of all, we support the concept that "the hospitals should be retained and their mission redefined to reflect the broader missions of the Health Services Administration and the Public Health Service." Nor do we see objection to the proposal that underserved populations, who are eligible for federally financed services, be admitted to PHS care. We assume that augmented case loads resulting from such admissions would, for the most part, be on a reimbursable basis. The result would be to meet presently unmet health needs without appreciable added cost, and it would have the effect of producing a sufficient patient volume for more acceptable cost-effective services.

CHANGE IN NOMENCLATURE

Prior to August 14, 1912, these institutions were known as "Marine Hospitals" and patients were almost solely confined to the seamen category. At that date, the name was changed to expand the program to other types of beneficiaries, finally forming a secondary, as distinguished from a primary, group of beneficiaries, albeit most at first were sea-occupationally related. The name "Marine Hospitals" became the United States Public Health Service as a result of this growth. Therefore, the recommendation of the committee that other health case expansion occur to offset average daily patient case load losses is not necessarily an unhistorical innovation and would, at the same time, greatly benefit the communities served.

SEAMEN'S CASE LOAD IN RELATION TO TOTAL BENEFICIARIES

Today, we have less seamen in PHS Hospitals than in the previous decade or so. This is due to several causes. Included is the low ebb in merchant shipping and in the size of our total merchant fleet; the displacement of many ships due to construction of large container and super-tanker vessels, as well as barge-carrying ships such as the Lash and Seabee types. Associated with such vessel displacement is a corresponding reduction in employed seamen. However, the seamen's admissions and average daily patient load does not show a marked decline since 1972, as the attached table tends to indcate.

In outpatient visits to PHS Clinics located outside the PHS general hospitals, themselves, the percent of seamen to total beneficiaries actually increased from 1972 through the estimated first 6 months of 1979. The range fluctuated from 26.7 percent in 1972 to 30.2 percent estimated for the first 6 months of 1979, reaching a high of 33.8 percent in 1974.

In outpatient visits to Clinics located with the PHS general hospitals, the percentage ranged from 30.3 percent in 1972 to 30.2 percent in 1978 with the first 6 months of uncompleted 1979 at an estimated 27.4 percent.

In inpatient days in the PHS general hospitals, the range of seamen remained rather constant, starting with 48.6 percent in 1972 and continuing in close range with 47.7 percent for 1978, but reaching 50.4 in 1973.

Turning to admissions, the range has been from 38.7 percent in 1972 with 39.4 percent in 1978 and 36.1 percent for the estimated first 6 months period of 1979.

As to average daily patient load, the percent of seamen to total beneficiaries was 48.5 percent in 1972, 47.7 percent in 1978 and an estimated 45.1 percent for the first

6 months of 1979. Actually, the percent of seamen in the average daily patient load held rather well for most of the period, reaching 50.4 percent in 1973, 49.6 percent in 1974, 47.3 percent in 1975, 46.0 percent in 1976, dropping to 40.3 percent in 1977, and then climbing again to 47.7 percent in 1978.

Over the years seamen have ranged close to the spread of 45 to 50 percent of the beneficiary case load when shipping was in a more flourishing state. Today, with only 563 active U.S. flag ships, of which only 539 are privately owned, seamen are still holding their rather normal percentage in average daily patient load.

The situation, therefore, comes down principally to a matter of total case load rather than to the relationships between existing types of beneficiaries as against the seamen category.

It seems obvious that, numerically, the current case load including seamen may not, in some cases, provide, quantitatively, the necessary patient load for the most efficient delivery of health care. However, the Ad Hoc Committee report clearly notes that—"the nation has a current public policy of assuring American seamen and certain others of access to and financing for a range of services to be delivered through the system of PHS Hospitals and Clinics." Recognizing this quantitative diminishing of the total beneficiary level, the committee suggests expansion through admission of other eligible beneficiaries, and better serving the communities and areas reachable from such hospitals. These hospital facilities could well render outstanding service in the fields of cancer and heart research, drug addiction and scores of other areas of unmet national health needs.

RECRUITMENT AND RETENTION OF STAFF

Turning to the staffing problem, we strongly support the Ad Hoc Committee's recommendation that "recruitment and retention of adequate and competent staff is the most crucial problem facing the hospitals." The committee noted "that appropriate steps must be taken to enhance recruitment efforts and that the negative impact of position ceilings must be eliminated." This condition is, in great measure, the result of the many past vicissitudes and uncertainties associated with varied and sundry attacks upon the PHS program. These have not only accentuated staff loss, but are equally as detrimental in the recruitment of new staff. In 1965, a concerted effort was made to close seven of the general PHS Hospitals and a Presidential order was actually issued to do so. This was rescinded following Congressional hearings that year.

In 1971 similar attempts were made and the uncertainty as to the future status caused many professionals to leave. These attempts had equally deleterious effect on recruitment at that time.

In 1973 there was a movement to close inpatient admissions early in the year to be followed later by closing the hospitals, themselves, and, of course, with a corresponding shelving of the intern-matching program. This unfortunate trend was reversed due, in great measure, if not entirely, to Congressional dissent.

Adoption of the Ad Hoc Committee's recommendations should provide a more well-rounded Public Health care program with PHS Hospital facilities related more directly to community needs and health systems.

RETIRED SEAMEN AND DEPENDENTS

Dependents of eligible seamen and retired seamen should be permitted to purchase services from PHS Hospitals and Clinics. H.E.W. should use its authorities to assure appropriate reimbursement for such proposed beneficiaries. The AD Hoc Committee made specific recommendations in support of such eligibility for dependents of eligible seamen and retired seamen. It is to be noted that both retirees and their dependents from the U.S. Coast Guard, Public Health Service, and NOAA are eligible now on a non-reimbursable basis, as are their dependents. Retired personnel of the Department of Defense are eligible now on a reimbursable basis, as are their dependents. We understand this does not include outpatient care. These are all government employees.

It would appear fitting that the retired seamen of our Merchant Marine (which constitutes our fourth Arm of Defense), and their dependents, be made eligible for PHS Hospital care on a non-governmental reimbursable basis. We support this recommendation of the Ad Hoc Committee, also.

PATIENT ADVISORY COUNCILS

We support the concept of Patient Advisory Councils to the hospitals, believing they can be a valuable asset in conveying patient attitudes and reactions to hospital care and in assisting the hospital management in "anticipating and responding to patient needs." One of the first such Patient Advisory Councils was in Seattle where, we understand, it worked quite well and especially so, we believe, from the seamen's point of view. We have heard good reports from seamen on the work of the Patient Advisory Councils.

BASIC CONCLUSIONS

In summary, we set forth the following conclusions of our organization:

1. Recruitment and retention of adequate and competent staff is one of the most essential needs of the PHS Hospital and health care program. Contributing uncertainties of the past so detrimental to this objective should be eliminated by assured continuity of the program.

2. The PHS Hospital program should be expanded to ensure the most effective delivery of health care services by greater integration with the needs of the communities and areas served. Such expansion should be on a reimbursable basis to the greatest possible extent to avoid added government expense.

3. Increased case loads should be achieved through added beneficiaries eligible for health care—again on a reimbursable basis. To the extent possible retired seamen and seamen dependents should be admitted to such at reimbursable cost.

4. The PHS Hospital and health care program should continue its traditional leadership role as a prime medical and research institution serving the nation's health needs, but should also become a community resource for increased access to primary health care coordinating its planning efforts with community health systems agencies.

5. Patient Advisory Councils, where instituted, have been successful and are advantageous to the delivery of health care by bringing patient attitudes and suggestions to the hospital authorities.

6. Even with the current slump in shipping, and reduction of maritime employment, the seamen case load has generally maintained its traditional percentage level of paitients in relation to total cases. This is expected to continue and could even increase with future growth of the U.S. flag merchant fleet.

7. The change in name for PHS Hospitals from the earlier nomenclature of "Marine Hospitals" to "U.S. Public Health Service Hospitals" to the Ad Hoc Committee suggestion of "Public Health Service Center for Health Care" is a progressive development. We see no objection to the latter terminology application if other recommendations of the Ad Hoc Committee are adopted, particularly the expanded eligible beneficiary case load and greater integration with community health needs.

8. Research and training is the essence of future success in health delivery services and should be expanded. The tie-in with local universities and medical training institutions, already so successful in some areas, should be encouraged.

9. Cost effectiveness should be a goal of every institution, governmental or otherwise. A sharing of experience between government and private medical institutions should be pursued to develop planning guidelines, and quality standards for improvement in the total delivery of health care.

Mr. CLARK. Mr. Chairman, I am happy to appear before the committee today and in connection with the subject at hand. Mr. Simpkins asked that I express his regret that he could not be here. He is in New York City today.

In the labor-management maritime community, we divide our work. Mr. Simpkins handles the ship work matters and I give my attention to treatment of the basic Public Health Service hospital programs, and where it is going and where we find weaknesses and some possible strengths.

We met with Dr. Erickson and others and decided that we should like to round out the record here. By giving the treatment of the Public Health Service hospitals a great deal of what has been testified to, would find a broad gap, indeed without the basic health programs of the health services and clinics. PHS Hospitals are high on the list of medical care, coordination, and training, and its relationship to shipboard care. Some of these other programs might indeed diminish or fall short were it not for the basic services provided by the Public Health Service.

We are happy to find, too, that the PHS Ad Hoc Advisory Committee Report to the Secretary has greatly reversed the trend of the past few years, from 1963 until the present time; and if their advice, counsel and recommendations are adhered to or adopted by the executive branch of Government, we shall certainly have a stronger PHS Hospital service to back up the services that have been described here as further need aboard ship.

In our report, Mr. Chairman, we have provided, as a part of the round out, a series of statistics that constitute the last page of our report, which we hope the committee might find useful in its reference to outpatient visits, in relation to seamen, both within the hospital clinics and the detached clinics. Inpatient days in Public Health Service Hospitals are divided again by all beneficiaries and American seamen, by admissions in general, and the average daily patient load. We find in these statistics that the seamen are holding their usual percentage with reference to both the primary beneficiaries and with respect to the total beneficiaries. So that we also treat our physician, item by item, on page 9 of our report with regard to the conclusion reached with respect to the PHS Ad Hoc Advisory Committee recommendations.

We think all of this material, as a round out to your broad information in connection with shipboard care, would be incomplete without reference to the basic institution that gives the care to merchant seamen.

I will not take further time, Mr. Chairman, to elaborate on my report as it is somewhat lengthy, but I desire to file it with the committee and I will be happy to answer any questions with regard to it.

The CHAIRMAN. Earl, you point out that the hospitals continue to serve the same number of seamen now as they did in 1972. If the hospitals were to dramatically increase the number of community patients served, do you have any concern that their ability to perform their primary mission would be hampered?

Mr. CLARK. No, I do not, Mr. Chairman.

We have now in the hospitals considerable range of eligible patients other than seamen. We have had that since 1912. As you know, prior to 1912, it was called the Marine Hospitals and at that time they changed the whole nomenclature in order to admit other beneficiaries. Many of the beneficiaries are seafaring related anyway.

Now, your question as to whether they opened the gap a little further and brought in other eligible beneficiaries is a good one. One of the recommendations we make here is that retired seamen and their dependents be admitted to Public Health Service care. That, of course, could be on a reimbursable basis, and without cost. I assume any extra cost to the Government would be minimum.

I think in our report, when we treat the other classes that would be admitted to make a better caseload, those would also be principally on a reimbursable basis. We are not suggesting that we add to the Government's expense very significantly in our recommendations here.

Getting back to a direct answer to your question, I do not have any clear path. May I just add this, I think the opinion of the hospital authority still is that a rounded average daily patient load of about 250 a day, average daily patient load in nonadmissions, not outclinics, is the best size. We have some hospitals that fell below that, as you know, and there were some that closed like Detroit and Savannah. I do not know all of them that were in that level, but they found they had a workload.

So, in order to preserve basic caseloads, adequate to give the highest proficiency of medical care, there is a need now to do this.

Mr. Chairman, we point out that the larger the ships, the less the seamen. We have a pretty low ebb now, with the least seamen employed. Yet, in the face of this situation, we have held our percentage of seamen. In fact, the seamen that are in the hospitals now, in relation to the total seamen, is a greater percentage than the number of seamen in the hospital today with reference to what the total seamen used to be when we had a large merchant marine.

So seamen are holding their own.

The Chairman. Thank you.

Capt. Bob Lowen, president, Masters, Mates & Pilots International?

Mr. Lowen. Mr. Chairman, my name is Robert J. Lowen. I am president of the Masters, Mates & Pilots International, and with the chairman's permission I would try to confine my remarks to a few brief comments on the prepared statement that I would appreciate being inserted in the record.

The Chairman. Your statement will be inserted in the record at this point.

[The following was received for the record:]

Statement by Capt. Robert J. Lowen, President, International Organization of Masters, Mates and Pilots

Mr. Chairman, and Members of the Subcommittee on Merchant Marine: My name is Captain Robert J. Lowen. I am President of the International Organization of Masters, Mates and Pilots, an autonomous union affiliated with the International Longshoreman's Association. The Masters, Mates and Pilots supply the largest percentage of union masters and deck officers aboard American flag vessels. Our members are primarily responsible for the navigation and safety of vessel, crew and cargo. In carrying out these duties, our members are also responsible for the administration of medical treatment aboard ship.

We are very pleased to address this Committee on a matter of highest importance to the American merchant seamen, who live and work in an isolated and often hostile environment. Minor injuries and illnesses are frequent. Occasionally, major illnesses or injuries occur. When this happens, the sick or injured seaman must rely, at least initially and perhaps for a period of days, on the medical skills of the master, deck officer, or staff officer who will provide treatment. With the rising age of American merchant seamen, it appears that medical problems encountered aboard ship are increasing. Additionally, the trend of reduced manning on American flag ships will exacerbate this situation by increased hours of work, and increased isolation among the crew. Less opportunity for interaction between members of the crew will attenuate psychomedical problems occasioned by the isolation of a life at sea on fast turn around vessels. It is my belief that the delivery of health care aboard ships will become even more critical than it is today.

The master of American flag vessels is charged with the duty to provide such medical care and attention as is practicable under the circumstances. *The Iroquois*, 194 U.S. 240. This ancient obligation arises out of the seaman's contract of employment and his relationship to his vessel. *Central Gulf S.S. Corporation v. Sambula*. 405 F.2d 291, 1968 AMC 2521 (CA5 1968). The master's obligation is not only to provide medical care, but he must also ensure that this care is reasonable under the circumstances. He must seek assistance if required. If the master fails to provide this care, or seek available assistance, he as well as his shipowner/employer can be sued by the aggrieved seaman.

Generally, the shipowner must pay not only for the maintenance and cure of the seaman, but must take all reasonable action to ensure that the sick or injured seaman receives proper care and treatment. In some instances, the master must deviate from his intended voyage in order to seek medical attention at the nearest port, or from a passing vessel which has a physician aboard. In the case of *The Governor*, the Federal Court stated:

"I think that due care requires that the judgement of officers when dealing with injured seamen should be exercised not only with such knowledge as they possess, but also with such that they can readily acquire."

This deviation is obviously an expensive undertaking given the high cost of fuel and other operating expenses of large vessels today.

If humanitarian concerns alone were insufficient to bring home the importance of providing medical treatment to seamen, the potential legal liability reinforces the master's contractual duty to provide medical care.

The members of the Masters, Mates and Pilots have performed remarkably well considering the limited training and resources available to them until recently. Prior to the Fall of 1978, the *Ship's Medicine Chest*, the recognized manual for shipboard medical care published by the U.S. Public Health Service, had not been revised for a period of 31 years. Additionally, although the United States Coast Guard has the regulatory authority to require specific items be included in the ship's medicine chest, no standard list of medicine or equipment has ever been promulgated for American flag vessels. Communication with Public Health Service hospitals in medical emergencies often involved delays of hours. No facility had offered training for deck officers specifically directed at the needs of merchant seamen. The training needs of the deck officer providing medical care exceeds the scope of the basic Red Cross First Aid Treatment course. Working under these limitations, the deck officer functioning as a medical officer aboard ship consulted out of date first aid texts and did all he was able to alleviate the problem. On vessels which carried Marine Physician Assistants, or a purser/pharmacist mate, the situation was a great deal better.

These men, members of the Staff Officer Association, have received extensive training through the U.S. Public Health Service and received certification by that organization as Marine Physician Assistants. On ships manned with a person of this background and training, both the master and crew have received more competent medical treatment and have felt more confident of their well being on board ship. I cannot say enough about the job that these men have done in providing medical treatment to their fellow crew members. The quality of medical care aboard ship would greatly increase if all American flag vessels were required to carry a purser/marine physician assistant. However, only one ship in eight flying an American flag has a Marine Physician Assistant. The economics of the steamship business have effectively precluded the carrying of pursers/marine physician assistants on the majority of American flag vessels. Moreover, the U.S. Coast Guard which sets manning scales, has not required that such an individual be carried on American flag ships.

Because of this distressing situation, the Masters, Mates and Pilots recognized the need for additional training for their members in order to ensure the well being of their own brother officers and members of the unlicensed crew. To accomplish this, the Masters, Mates and Pilots has initiated a four week training program in shipboard medical care at their training facility, the Maritime Institute of Technology and Graduate Studies. In developing this course, many discussions took place with the U.S. Public Health Service, the medical offices of various steamship companies, and most importantly with our members who are charged with delivering health care aboard ship. Members of the Masters, Mates and Pilots were asked to identify medical problems which occurred frequently aboard ship. They were than asked to list the problems in order of seriousness and frequency in order that our training program could be directed in the areas most needed. Over a period of months our curriculum evolved. The first course in Shipboard Medical Care began in November 1978. Graduates of this program are certified as Emergency Medical Technicians by the National Registry of Emergency Medical Technicans in Columbus, Ohio. Additionally, areas not required of Emergency Medical Technicians, such as suturing, injections and advanced life support systems are included in the course. To insure objectivity, all testing is done by Registered Nurses and Certified Paramedics from outside the training facility.

The thrust of the MM&P Shipboard Medical Care program is not only first aid, but also a comprehensive program that conforms to the recommendations of the U.S. Public Health Service, as set forth in the *Ship's Medicine Chest and Aid at Sea.*

Deck officers successfully completing the program can and do function as the eyes and hands of the physican carrying out medical directives of the shoreside physician. On rare occasions, the deck officer functions on his own to stabilize the patient until further care can be sought.

It is noteworthy that a similar shoreside system of health care delivery presently exists and has proven to be both efficient and cost effective.

This program has been extremely well received by the members of the Master, Mates and Pilots. We do not pretend that this is the total solution to the problem, but we do believe that it will have a marked effect on the quality of medical treatment afforded to crew members of American flag ships.

The International Organization of Masters, Mates and Pilots is extremely gratified to note a change in attitude in the Department of Health, Education, and Welfare concerning the treatment of seamen at U.S. Public Health Service facilities. At one time there appeared to be an effort on the part of the Department of Health, Education, and Welfare to discourage merchant seamen from availing themselves of the services offered. It is heartening to note the present efforts of this Department and their Health Services Administration in investigating ways to enhance their delivery of health care to American seamen.

However, I would like to offer some criticism of the U.S. Public Health Service, which I trust will be of a constructive nature. Men attached to ships have often encountered long delays in seeing a Public Health Service physician. While I recognize that this is sometimes the case in doctors' offices ashore, seamen must return to their vessels in a short period of time due to the short stay of the ships in port. The master and employer company must know if a seaman is to be replaced for medical reasons, and delays at the Public Health Service facilities have resulted in additional costs to the vessel.

Additionally, there exists a lack of understanding of the shipboard environment by physicians at the U.S. Public Health Service Hospitals and Clinics. Presently a seaman who visits one of these facilities will receive one of four duty status reports: fit for duty, not fit for duty, not fit for duty for a period of time, or fit for light duty. Fit for duty clearly means the seaman can return to his vessel and work. Not fit for duty clearly means he cannot. The remaining two categories have been a cause of great concern to those who provide medical care to seamen aboard ship. These status reports put the master in a state of uncertainty with respect to the crewmen who receive one of them. In the case of not fit for duty for a few days, a master must evaluate whether or not the man has been cured. If he reaches the wrong conclusion, the health of the seaman can be adversely affected. Additionally, the master may be exposed to the liability mentioned previously. In the case of fit for light duty the situation is even worse. There is no such thing as light duty aboard ship. This means that the individual will not be allowed to work at all for fear that his illness or injury might be aggravated. In order to insure that the work that should have been performed by this individual is accomplished, another member of the crew is assigned additional duties, usually resulting in the payment of overtime. Again, the master must decide when the seaman has achieved a cure and can be returned to full duty.

The physicians issuing these duty status reports do not understand the hardships of a shipboard work environment. Additionally, the vessel may be leaving on an extended voyage with a period of weeks elapsing before the opportunity for examination by another physician. Should the seaman's condition deteriorate, a diversion may be required at great expense. I respectfully submit that the Health Service Administration and the U.S. Public Health Service investigate the environment on board ship, the responsibility of various members of the crew, and apprise their physicians of their findings through an in-house education seminar. In short, the current practice of issuing fit for light duty or unfit for duty for a period of days should be abolished. The health and safety of the seaman who reports to a U.S. Public Health Service facility can only be guaranteed if his duty status is clear cut. He is either fit for duty or unfit for duty. Any other duty status report places an unwarranted risk on the seaman should his medical condition deteriorate after the vessel has left port.

One more area that can be improved is that of communications between the ship and the U.S. Public Health Service facility in cases of severe medical emergency. As stated previously, oft times there is a delay of hours before advice from the U.S. Public Health Service is received. It is easier to transmit a World Cup Soccer Game from Brazil via satellite than to receive medical advice in a timely fashion in the current communications system. It would be extremely helpful if satellite communications were available on all American flag vessels to establish immediate contact with U.S. Public Health Service. Such a system has been tested at the National Maritime Research Center and proved effective. As you know, in medical emergencies, minutes can mean a life. To save hours, I am sure, would save a great many lives or lessen the severity of injury or serious illness.

Additionally, it would be beneficial if the U.S. Public Health Service maintained a central data bank of the medical histories of American seamen so that this information could be retrieved and evaluated, along with information received from the ship, to determine the proper course of treatment for individual seamen.

Under the existing Marine Navigation Laws, the United States Coast Guard acts as the regulatory and enforcement agency responsible for the preservation of life and property at sea. Present United States law requires American flag vessels to carry a medicine chest. However, the contents of same are not specified. As a result, wide variations in the types of medicines and equipment found from ship to ship and company to company exist. Standardization of the medicine chest would greatly facilitate communication between the ship and the U.S. Public Health Service facility. Additionally, standardization would enable the medical officer aboard any ship to utilize medicines and equipment specified without a long familiarization process. We believe that the recommended list found in the new *Ships Medicine Chest and Medical Aid at Sea* is an excellent starting point. Of course, any required list should be periodically updated, hopefully, more frequently than 31 years.

In summation, the lot of the seamen medically speaking has advanced tremendously since the days of Richard Henry Dana; however, much remains to be accomplished. The International Organization of Masters, Mates and Pilots recommends the following. If possible and practicable, all offshore American flag vessels should be required to have a Marine Physician Assistant aboard. If this cannot be done, we of the International Organization of Masters, Mates and Pilots will continue to maintain the highest standards possible in our medical training program with a view toward providing at least one medically trained deck officer on every ship we man. Additionally, all members of the crew should receive instruction in basic first aid.

The Public Health Service is to be commended for their efforts in revising the *Ships Medicine Chest and Medical Aid at Sea*. However, they should begin an in-house educational program to acquaint their personnel with shipboard life, and the responsibility and job tasks of men who sail our ships. They should improve their capability to respond to requests for information in medical emergencies, and establish and maintain a medical data bank from which they can elicit medical histories in such emergencies in a short period of time.

I would like to thank this Committee for your continued interest in investigating all avenues to enhance the safety and welfare of the American merchant mariner. I am confident that this inquiry will be concluded swiftly and that the safety and welfare of an unrecognized endangered species, the American seamen will be greatly improved.

Mr. LOWEN. Mr. Chairman, basically the prepared statement that will be inserted in the record covers three aspects of the committee's interest in the hearings. They speak to the level of seagoing care, the U.S. Public Health Service, and the link between the ship and the Public Health Service itself.

We represent the masters and the licensed naval officers, not only the unionized ships of the American merchant marine, but also those who are unable to speak for other reasons. A number of the witnesses already have spoken to the fact that the master is charged with the statutory and regulatory authority, the legal responsibilities, and the legal obligation to provide a duty of health care that is commensurate with the standards that have been laid down by both the courts and the Congress.

The tools he has at his command are only three. He can have a licensed physician—and there are only five ships in the American merchant marine now carrying a licensed physician; he can have the benefit of a marine physician assistant, if the staff officers are capable of convinincing a company that they should include them in the manning of their vessels; and I believe that Mr. Lanphur has already spoken to the fact that there are only 100 or so vessels manned with staff officers; or they can rely on exactly what has been done for centuries, and that is turn to the master and say: "Well, Captain, who do you want to be the doctor?" He usually ends up selecting one of the deck officers saying go ahead and take care of the sick.

In that context we have, at least in our meetings, the sad commentary that has been spoken to you already on the low level of health care. We decided, after consultation with some of our companies, that if in the labor movement we could not do what had to be done for the seamen, then we take the bull by the horns and prepare our own course—to at least provide a higher level of training and a better standard of medical knowledge for our officers.

I have heard it suggested in certain testimony that anyone can be trained to be able to provide the standard of medical care aboard a ship. I disagree with that. It is clear that one of the problems—and I believe this is borne out with both Coast Guard and USPHS comments—one of the problems that always seems to be present is the lack of communication; not so much the physical lack of communication, because the physical lack of communication is something that could be overcome easily with a hand operator.

We have done that dozens of times on ships which I commanded, where we wake up the duty officer and talk to him on a single sideband without resorting to expensive satellite communications or anything.

The problem really lies in the individual who is going to read the ship's medicine-at-sea book, or the manual. Being able to understand—primarily through this educational level what the words mean, or how they are pronounced, or what the intent of the suggested diagnostic procedures really are. It is one that almost by its very nature forces the master to be selective in choosing the officer to whom he assigns the medical duties.

It is clear that where you have a medically trained staff officer aboard, he is the obvious choice. I myself have had a third cook whom I used to assign, at one time, because he was a 3-year medical student, and he had actually flunked out before, I believe, performing an operation that was considered illegal in those days.

But for the most part the deck officers do the job. We, as I indicated earlier, looked at the situation that was on the ships, and sat down with some of our companies, and asked for their opinions of how we could at least raise the level of health care.

I must tell you there was a tremendous amount of resistance. We were refused to do any brain surgery, to perform appendectomies, and by the time we had the administrative officers of some of the companies, including the Health Department, sitting down with us and going through the type of curriculum we felt would be helpful, their attitudes changed.

We did initiate a course we chose rather than going to physicians to teach our people. We would go to the type of people they had to work with, and were most familiar with, and those are people who are trained in technical operations, paramedic type of things.

We were fortunate, and we succeeded in our obtaining the services of Mr. Don Merker, who is sitting in back of me, who is the director of our school training program. We teach them 160 hours—clearly well below the 2,000 hours that are needed for standard training in the type of marine physician assistants program, but still it is adequate for what we need, because pragmatically speaking, unless the Congress, or unless the Coast Guard, by regulation or statute, decides that they are going to include, in the manning scale of American merchant vessels, a marine physician assistant, you have to do the best you can. We have chosen that route.

Now, turning to the USPHS. In our prepared statement there are several comments that I think are germane to the Public Health Service Hospitals themselves. They place, again, on the master the problem of when is a man fit for duty, and when is he not fit for duty, and how long should he be fit for duty. They place the burden on him of deciding, although he is not a physician, even though he may have had MP training, whether or not the individual who has a duty ship is in fact fit for duty, with all of the attendant problems, the attendant legal problems for both the company and himself on a personal liability.

The Coast Guard, in the somewhat generalized profile they have submitted for determining the level of health an individual should have prior to entering the merchant service, or upgrading in his rating, seems to have taken the approach that the simplest way to solve the problem of health care at sea is to have everyone healthy, or healthy to the extent that they need no care, except in emergency medical care.

Clearly, there is a ring of familiarity of the document they submitted, but I do not think I can comment on it from the point of absolute knowledge.

But the Public Health Service Hospitals, in the interface with the ships, can do several things to improve the standard of health care.

One is creating and maintaining a data bank on individual seamen who do have health problems. A second is insuring that the duty officer is in fact available when he is supposed to be on duty, so when you make a call, you do not have a 2- or 3-hour wait, while someone is busy doing something else, like delivering a baby, or filling out a set of forms to complete his workshift.

But if they do those things, if they make the Public Health Service Hospital once again a marine hospital, as Mr. Clark referred to, and recognize that that was the original reason for it, to give priority to the seamen, understand what the problems of the seamen and the ship are, make themselves available when they have to be available in the emergency situations which we are referring to, then certainly I think the actual aims of the health service and the overall care of the merchant seamen will be advanced.

Thank you, Mr. Chairman.

The CHAIRMAN. In your statement, you said that only one in eight U.S.-flag vessels carry a marine physician assistant. Are these vessels in competition with other flag vessels?

Mr. LOWEN. Yes, they are, Mr. Chairman. I suggest, if I may amplify on that, it is no secret to any of us who negotiate with the companies that there have been several attempts in the last three rounds of negotiations to eliminate the marine physician assistants.

The CHAIRMAN. Is the profitability of those vessels suffering because their manning includes this specialty?

Mr. LOWEN. I do not believe so. The cost of the marine physician assistants clearly is a subsidized cost. It is recoverable, at least to the extent of subsidy; and if the facts and the figures bear out the suggestion that the shipowners, P. & I. courses are lower, as a result of the improved level of health care, then clearly it is either a push, or it is an advantage to the shipowner.

The CHAIRMAN. What are the costs of diversion to obtain care for seamen?

Mr. LOWEN. That can depend on where you are diverting to, Mr. Chairman. I have diverted a ship I have commanded as many as 8 days to put a man ashore who was suffering severe abdominal injury, and then have to go 8 days back again.

If you are recognizing that an SL-7, or sea-land, costs as much as $40,000 a day, that is a great deal of money.

The CHAIRMAN. What about the replacement costs for the disabled seamen?

Mr. LOWEN. I am sorry?

The CHAIRMAN. What about the replacement costs for disabled seamen? You have lost a man, and you have to replace him.

Mr. LOWEN. Those costs are minimal. When you realize that to divert, first, you have a man who is so seriously ill, or you are so uncertain about the prognosis of whatever his illness is, that you consider it almost an absolute necessity to divert, under those circumstances. You will usually end up flying a man out to relieve him, and then it is the cost of air fare, and double the cost of one seaman who is replacing another one who is clearly on unearned wages at that point.

The CHAIRMAN. And what about the repatriation cost of the seaman you have left behind? If you have left him in a foreign country, you have to bring him back?

Mr. LOWEN. That is correct, sir.

The CHAIRMAN. This is quite a cost which is involved. Did you hear Admiral Bell's testimony earlier today? If so, would you comment on some of his proposals?

Mr. LOWEN. I did not have an opportunity to read Admiral Bell's testimony, Mr. Chairman. I came a little late, thanks to Eastern Airlines.

The CHAIRMAN. Eastern Airlines is still suffering from the DC-10 problem, along with the other airlines.

Mr. LOWEN. I think the 8 o'clock shuttle got off at 10:10 this morning.

The CHAIFMAN. Gentlemen, we appreciate your appearance before the committee. Thank you very much.

The CHAIRMAN. Our final witness is Dr. Gareth Green.

STATEMENT OF DR. GARETH GREEN, CHAIRMAN, DEPARTMENT OF ENVIRONMENTAL HEALTH SCIENCES, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD.

Dr. GREEN. Mr. Chairman, I have submitted a full copy of these remarks for the record, and recognizing the lateness of the hour, I would be pleased to abstract or summarize these comments, if they could be submitted.

The CHAIRMAN. Without objection, the entire statement will be placed in the record.

If you will proceed, Doctor.

[The following was received for the record:]

Prepared Statement of Dr. Gareth M. Green, Chairman, Department of Environmental Health Sciences, The Johns Hopkins University School of Hygiene and Public Health

Mr. Chairman, members of the committee, it is a privilege to appear before you today and to present a brief outline of a new cooperative effort between The Johns Hopkins University and the U.S. Public Health Service Hospital at Baltimore. This Center is designed to address the pressing need for the recognition, assessment, treatment and prevention of death, illness, disability, and human misery caused by agents and conditions in the work place and the general environment. I am Chairman of the Department of Environmental Health Sciences at The Johns Hopkins School of Hygiene and Public Health. This Department is a large, multidisciplinary and multiprofessional assemblage of basic scientists, environmental and occupational physicians, and environmental engineers dedicated to the discovery, understanding, and control of occupational and environmental factors that produce illness and disability in the workers of this country and in the general population. Our resources are augmented by the oldest and largest school of public health in this country, and perhaps in the world, by the extensive medical resources of the Johns Hopkins Hospital and School of Medicine, and by the expertise of distinguished faculty throughout the Johns Hopkins University. My background includes training in infectious and pulmonary diseases at Harvard University, clinical medicine at the University of Washington, and environmental diseases with the Medical Research Council Unit in Great Britain. My professional interests lie at the interfaces of scientific research, clinical and preventive medicine, and environmental control.

A key question that faces medicine and public health in this country in the ninth decade of this century is how to integrate our massive health care delivery system with its enormous capability for medical treatment of disease and our public health delivery system with its emphasis on prevention of disease through immunization and environmental control. We believe that the U.S. Public Health Service hospitals and clinics can provide a unique service in addressing this question, and it is toward that end that a cooperative center was established between The Johns Hopkins University and the U.S. Public Health Service Hospital in Baltimore a little over six months ago.

The Cooperative Center for Occupational and Environmental Health (CCOEH) is founded on an agreement between the two institutions to undertake a collaborative effort to develop facilities, staff, and program to effectively address health problems associated with the work place and the general environment. The University brings to this collaborative effort the scientific and technical capability, the basic and applied research programs, and the opportunities for education and training which are integral parts of these functions. The U.S. Public Health Service Hospital will provide the inpatient and outpatient clinical facilities for patient care and evaluation and for the health assessment of potentially exposed populations, the organizational and administrative resources of the Hospital, and physical laboratory and office facilities for the scientific and medical staff.

The Center is organized in three components: first, a clinical Department of Occupational and Environmental Medicine responsible for medical assessment and treatment of individuals injured or made ill by environmental exposures or conditions; second, a Field Program Service which will provide an epidemiological, medical and engineering team to investigate environmental or occupational problems in the field and will be available for consultation by government, industry, and small business establishments; and third, a supporting Applied Research Laboratory which has the capability to examine and analyze environmental and biological samples for evidence of toxic exposures and conduct basic studies of the effects of toxic chemicals on biologic systems.

We believe the combination of medical, environmental, and laboratory facilities within the context of a public health service facility will provide a useful service very much needed in the community for it will make available to small industry the medical-nursing, toxicologic, industrial hygiene, and epidemiologic services that are usually restricted to large companies. This is important because of the high incidence of occupational illness in businesses with less than 500 employees. Although we have just moved into this facility this month, we already have been contacted by agencies of the federal government, national industrial corporations, major labor unions, and state governments for assistance.

The Center has the following objectives:

1. To identify CCOEH, located at the Baltimore U.S. Public Health Service Hospital, as the focus of clinical and applied research resources in occupational and environmental health.
2. To establish medical evaluation, teaching, and clinical investigation and research as the three activity proposes of the CCOEH.

3. To establish a joint Johns Hopkins University-U.S. Public Health Service Hospital Policy Board to direct the CCOEH.

4. To establish as the CCOEH's clinical mission and integrated clinical response to occupational and environmental disease, including screening, identification, evaluation, measurement, and treatment of disease; and identification, evaluation, measurement, and rehabilitation of disability. This effort will have a special focus on the needs of Merchant Seamen, Coast Guardsmen and other PHS beneficiaries and can also impact on federal employees utilizing the FEOH Program.

5. To directly link the Occupational Safety and Health Educational Resource Center (OSHERC) sponsored by the National Institute for Occupational Safety and Health (NIOSH) at the Johns Hopkins School of Hygiene and Public Health to the CCOEH to implement the educational mission.

6. To designate the Building 6 laboratories at the Baltimore U.S. Public Health Service Hospital as the Applied Research Laboratories in Occupational and Environmental Health to implement the research mission of the CCOEH.

7. To develop a field program for surveillance and consultation to help private corporations and public agencies address their environmental and health monitoring requirements.

8. To incorporate occupational and environmental health referral services into the outpatient clinic system of the Baltimore U.S. Public Health Service Hospital, and to offer these services to industry and government occupational and environmental health programs.

9. Utilizing these resources of the CCOEH, to develop a specific and intensive program to identify, characterize, and correct the occupational and environmental hazards to health and the medical conditions of Merchant Seamen, Coast Guardsmen, and other federal personnel.

There are additional special characteristics of the U.S. Public Health Service Hospital system and of the specific facility in Baltimore which appear to be particularly appropriate to this joint undertaking. First of all, the Baltimore U.S. Public Health Service Hospital supervises six Public Health Service outpatient clinics which stretch from Baltimore to the Midwest through a heavily industrialized section of this country. We envision that when the program becomes established, the resources of the Center may extend through the clinic system to a major industrial section of this country and provide this unique specialties resources as adjunct to the health care delivery system.

Secondly, the U.S. Public Health Service Hospital in Baltimore has initiated a primary care program designed to improve the availability and accountability of medical services to a community immediately surrounding the facility. This community is currently medically underserved, is a working-class community, and, as a result of the Center, will have available to it expertise in occupational health as well as the usual range of primary care medicine. Thus, the opportunity exists to develop and to integrate a broad preventive medicine program which incorporates environmental and occupational concerns with the more conventionally-oriented primary medical care program. This could provide a model that might have broader applications but will require careful development to insure that preventive services are effectively delivered.

Thirdly, the U.S. Public Health Service Hospital system was founded for an occupational group who experience unique occupational and environmental exposures—the Merchant Marine. It is a system that is already oriented toward occupational groups, although it has not pursued an occupational health direction. This advantage is perhaps more visible to those outside the system, such as in the major medical centers, where occupational medicine has not served a visible purpose. By the same token, the U.S. Public Health Service Hospital in Baltimore is a general hospital that relies heavily for highly skilled specialty work on nearby tertiary medical facilities, such as the Johns Hopkins Medical Center. The Cooperative Center for Occupational and Environmental Health is integrally tied to the Johns Hopkins Hospital and Medical Institutions, and thus has available to it when required extensive highly specialized expertise for complex medical or surgical problems.

Finally, the U.S. Public Health Service Hospital could develop the capacity to provide specialized medical services and facilities uniquely appropriate to occupational and environmental accidents, such as decontamination facilities, disability evaluation services, and job fitness programs, that may not be readily available in the disease-oriented medical care system, We believe there is need in the community for a center or an institution with these capabilities.

The U.S. Public Health Service Hospital with its traditions, responsibilities, and orientation, appears to provide a highly favorable setting for the development of this cooperative endeavor. As it is a public health facility, we are finding it is more readily accepted and approached by users in government, labor, and industry. The location of this Center is a major port such as Baltimore provides a favorable opportunity for investigating the occupational and enviromental hazards associated with the Merchant Marine and other beneficiary groups of the U.S. Public Health Service hospital and clinic system. Although this program is still in its very early stages, its rate of development and acceptance by the user community augurs well for its future development and establishment as a valid partner in the health care delivery and preventive medicine system of this country. Whether this approach would be appropriate for other segments of the hospital and clinic system is uncertain at this time, and it may be well to give this Center an opportunity to go through a period of experimental development before making such an assessment. However, at this time, we believe that at least in Baltimore, the U.S. Public Health Service Hospital and clinics have a mission in environmental and occupational health, have much to offer this field which has not flourished well in the existing medical care delivery system, and that its future role will be to augment the health care delivery system in the United States by providing an interface between that system and the work place and general environment, and between the medical care system, public health, and preventive medicine.

Thank you.

Dr. **Green**. Mr. Chairman, members of the committee, it is a privilege to appear before you today, and to present a brief outline of a new cooperative effort between the Johns Hopkins University and the U.S. Public Health Service Hospital in Baltimore.

The Cooperative Center for Occupational and Environmental Health is designed to address the pressing need for the recognition, assessment, treatment, and prevention of death, illness, and disability caused by agents and conditions in the workplace and the general environment. This center is staffed by faculty of the Johns Hopkins School of Hygiene and Public Health which, as you know, is the oldest and largest school of public health in the world. It is backed by the extensive resources of the Johns Hopkins Hospital, and the School of Medicine, as well as the expertise of faculty throughout the university.

The center was founded on an agreement between those two institutions to undertake a collaborative effort to develop facilities, staff, and programs, to effectively address health problems associated with the workplace, and the general environment. The university brings to this collaborative effort the scientific and technical capabilities, the basic and applied research programs, and the opportunity for education and training, that are integral parts of these functions.

The U.S. Public Health Service Hospital will provide the inpatient and outpatient clinical facilities for patient care and evaluation, and for the health assessment of potentially exposed populations, the organizational and administrative resources of the hospital, and physical laboratory and office facilities for the scientific and medical staff.

The center is organized in three components: The first, a clinical department of occupational and environmental medicine, which is responsible for medical assessment and treatment of individuals injured or made ill by environmental exposures or conditions.

Second, a field program service that will provide an epidemiological, medical, and engineering team to investigate environmental or occupational problems in the field, and will be available for consultation to government, industry, and small business establishments.

Third, a supporting applied research laboratory that has the capability to examine and analyze environmental and biological samples for evidence of toxic exposures, and conduct basic studies of the effects of toxic chemicals on biologic systems.

We believe the combination of medical, environmental, and laboratory facilities, within the context of a Public Health Service facility, will provide a useful service very much needed in the community; for it will make available to small industry the medical-nursing, toxicologic, industrial hygiene, and epidemiologic services which are usually restricted to large companies. This is important because of the high incidence of occupational illness in businesses with less than 500 employees.

Parenthetically, I might point out that most ships would fall into that size of a business establishment. Although we have just moved into this facility this month, we already have been contacted by agencies of the Federal Government, national industrial corporations, major labor unions, and State governments for assistance.

There are additional special characteristics, of the U.S. Public Health Service Hospital System, and the specific facility in Baltimore, which appear to be particularly appropriate to this joint undertaking.

First of all, the Baltimore U.S. Public Health Service Hospital supervises six Public Health Service outpatient clinics, which stretch from Baltimore to the Midwest, through a heavily industrialized section of this country.

We envision, that when the program becomes established, the resources of the center may extend through the clinic system to a major industrial section of this country, and provide this unique specialties resource as an adjunct to the health care delivery system.

Second, the U.S. Public Health Service Hospital in Baltimore has initiated a primary care program designed to improve the availability and accountability of medical services to a community immediately surrounding the facility. This community is currently medically underserved, is a working class community, and, as a result of the center, will have available to it an expertise in occupational health, as well as the usual range of primary care medicine.

Thus, the opportunity exists to develop and to integrate a broad preventive medicine program that incorporates environmental and occupational concerns with the more conventionally oriented primary medical care program. This could provide a model which might have broader applications, but will require careful development to insure that preventive services are effectively delivered.

Third, the Public Health Service Hospital System was founded for an occupational group who experience unique occupational and environmental exposures, the merchant marine. It is a system that is already originated toward occupational groups, although it has not pursued an occupational health direction.

This advantage is perhaps more visible to those outside the system, such as in the major medical centers, where occupational medicine has not served a visible purpose.

Fourth, the U.S. Public Health Service Hospital in Baltimore is a general hospital that relies heavily for highly skilled specialty work from nearby tertiary medical facilities, such as the Johns Hopkins Medical Center. The Cooperative Center for Occupational and Environmental Health is integrally tied to the Johns Hopkins

Hospital and Medical Institutions, and thus has available to it, when required, extensive highly specialized expertise for complex medical or surgical problems.

Finally, the U.S. Public Health Service Hospital could develop the capacity to provide specialized medical services and facilities uniquely appropriate to occupational and environmental accidents, such as decontamination facilities, disability evaluation services, and job fitness programs, which may not be readily available in the disease oriented medical care system.

We believe there is need in the community for a center or an institution with these capabilities.

The U.S. Public Health Service Hospital with its traditions, responsibilities, and orientation, appears to provide a highly favorable setting for the development of this cooperative endeavor. We are finding that it is more readily accepted and approached by users in Government, labor, and industry. The location of this center in a major port such as Baltimore, provides a favorable opportunity for investigating the occupational and environmental hazards associated with the merchant marine and other beneficiary groups of the U.S. Public Health Service Hospital and Clinic System.

Although this program is still in its very early stages, its rate of development and acceptance by the user community augurs well for its future development and establishment as a valid partner in the health care delivery and preventive medicine system of this country.

Whether this approach would be appropriate for other segments of the Hospital and Clinic system is uncertain at this time. It may be well to give this center an opportunity to go through a period of experimental development before making such an assessment.

However, at this time, we believe, that at least in Baltimore, the U.S. Public Health Service Hospital and Clinics have a mission in environmental and occupational health. It has much to offer this field which has not flourished well in the existing medical care delivery system, and its future role will augment the health care delivery system in the United States by providing an interface between that system and the workplace and general environment, and between the medical care system, public health, and preventive medicine.

I would think in listening to the testimony of my predecessors this morning, that much of what has been stated here is quite applicable to the problems which have been presented to this committee, and I would look forward, in the development of this center, to more active exchange ideas among those present at this hearing, and our own center.

Thank you very much. I will be pleased to answer any questions.

The CHAIRMAN. Thank you, Dr. Green.

HEW wanted to phase out tertiary care at the PHS hospitals. Is not the research that you are providing an adjunct to tertiary care?

Dr. GREEN. I think in the area of preventive medicine and particularly occupational health, the research that is needed is much more in the direction of primary care. In fact, it is even in advance of primary care.

The purposes of research in preventive medicine is to define those factors which lead to disease rather than those techniques which can be used to treat disease. These include not only toxic substances but also hazardous working conditions, psychological changes, and so forth.

The CHAIRMAN. On page 4 of your statement you state there is a high incidence of occupational illness in businesses with less than 500 employees.

How does this relate to the shipping business of individuals aboard ship?

Dr. GREEN. Thank you for calling attention to that sentence.

On rereading, I think the wording would be better as "proportion" rather than "incidence."

One of the big problems in the small industries is the relatively small amount of attention that is given to occupational safety and health, in part because these organizations are too small to be able to employ occupational physicians, nurses, industrial hygienists, occupational safety engineers, and so forth. It seems to me that this is exactly the situation we have been hearing about this morning on shipboard where with the relatively small number of employees or seamen are on board. It is very difficult to support a full range of occupational health and preventive medicine services. Therefore, I think the problems are analogous to the situation on shipboard and the situation of small industry.

Most of the regulatory and enforcement procedures that have been developed in this country do not really address that problem.

The CHAIRMAN. How important is the joint activity between Johns Hopkins and the Baltimore PHS Hospital to the effective of utilization of the PHS system?

Dr. GREEN. Mr. Chairman, I think we really do not know the answer to this. This center is in a sense a hypotheses which we are testing. I think we could hypothesize that this will have a significant impact on utilization of the facilities, staff, and services of the Public Health Service Hospital by providing a service which is not now available to the community.

Our hypothesis is that the availability of these services will create a substantial demand on the facilities of the hospital.

The CHAIRMAN. On page 7, you speak about the PHS Hospital serving as a model, with broader implications.

How would you view the PHS Hospitals as a model for health organizations, as a barometer for real cost measurement in the Federal health sections?

Dr. GREEN. That is a rather complicated question. I am not certain that——

The CHAIRMAN. It is a loaded question.

Dr. GREEN. I am not certain that I am prepared to address specifically the cost issues. The whole thesis of preventive medicine which is an integral component of occupational health and occupational medicine is that there are preventable causes of chronic diseases.

First of all, chronic disease is a very expensive cost to society, both in human suffering and in dollars and cents.

Second, a substantial portion of chronic disease is related to environmental and occupational exposures and conditions. Therefore, what the conclusion that is drawn from that—I am sorry, third, many of these exposures and conditions can be prevented and corrected by medical means, by environmental means, by engineering means. Again I think this would have to be stated as an hypothesis. The concept is not limited to the centers, there is an active debate going on, as you well know.

I think we need to test this hypothesis. In order to do this, the community will need a significant infusion of know-how, in the public health disciplines, the environmental health disciplines, epidemiology, and environmental health sciences. These do not exist, by and large, in the medical system as it is now established. It is perfectly possible for those capabilities to be introduced into the medical system and over time I think this will happen. The orientation a of medical delivery system is different. The ability to develop a community resource, first of all, I think would greatly accelerate this process and, second, would make it more rapidly effective in the community. These are Public Health Service disciplines. Their epidemiology is Public Health Services. It would seem quite logical to associate those kinds of academic resources with the community facility which is concerned with not only medical care but also prevention of disease.

The CHAIRMAN. I am going to ask counsel to confer with you when we adjourn at this time.

Doctor, thank you very much.

The committee will stand adjourned.

[The following material was submitted for the record:]

MATSON NAVIGATION CO.,
Washington, D.C., June 29, 1979.

Hon. JOHN M. MURPHY,
Chairman, Committee on Merchant Marine and Fisheries,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN MURPHY: We unfortunately were unable to participate in the hearing before your Committee on June 19 in respect to seamen's health, standards of care, and their effect on maritime transportation.

We would, however, sincerely appreciate the inclusion of the attached statement of comments and observations in the hearing record.

We would be prepared to supply you and the Committee with such additional information or commentary as you may deem appropriate.

Yours very truly,

JOHN R. KUYKENDALL.

Enclosures.

As a common carrier by water serving the State of Hawaii and the Territory of Guam with self-propelled vessels to and from U.S. Pacific Coast ports, Matson operates a total of 13 vessels with an average manning scale per vessel of 39.5 men which, after consideration of vacation and other absent time involves employment on an annual basis of approximately 1,028 persons. Since the largest number of these individuals are unlicensed seamen subject to the collective bargaining agreement between the Seafarers International Union and the Pacific Maritime Association, the employers' collective bargaining unit of which Matson is a member, this discussion will focus on those aspects of the agreement which have to do with the physical fitness and health of the members of the SIU.

By means of an Agreement and Declaration of Trust dated July 23, 1963, the SIU Pacific District and the PMA established a Seafarers' Medical Center, the activities of which are financed by a contribution from the employers of $0.52 per man day of covered employment supplemented by such other per man day contributions as may be required. Payment of these contributions by employers is to the Trustees of the Center consisting of representatives of both management and labor.

As a provision of this agreement, a pre-employment physical examination is required for seamen; although this examination is by any measure complete and comprehensive, it applies only to those individuals commencing their initial work experience in the industry. In addition to its application to all new applicants, these new physical standards and qualifications are to be adhered to in respect to all required annual physical examinations with the very important exception that "those seamen now established in the industry shall not be deprived of their livelihood by more rigid physical standards than were applied in past years. Consequently, in applying the physical standards of the Medical Center, seamen who have been sailing and who are physically capable of performing the duties of their rating despite the existence of physical defects covered by the more rigid standards of the Medical Center, shall not be denied eligibility to sail because they cannot meet these standards." A copy of these standards and qualifications is attached hereto as Appendix A.

In addition to the required annual physical examination, all crew members are required to have an examination prior to signing on for a voyage; this latter examination is, unfortunately, usually of a casual and pro forma nature.

In the event that any dispute arises on the question of a man's physical fitness, a man may exercise his contractual recourse and be examined by an official of the U.S. Public Health Service and their decision shall be final; in the case of a USPHS examination, there are no rigid standards followed that we are aware of. When a man is denied employment for medical reasons and the U.S. Public Health Service overrules the Medical Center doctor and gives the man a "fit for duty" slip, the man shall be assigned to the job; and in the event that his ship has sailed, the man involved shall be awarded ten days' wages. If the vessel has not sailed and the rejected seaman now classified as fit for duty by the USPHS joins the vessel, a potentially sensitive situation can evolve inasmuch as the vessel could be determined to be unseaworthy because of this individual's presence or because of his inability to perform his duty other members of the crew would be required to take on his duties.

The above recitation is presented for the purpose of highlighting that the present system of fitness evaluation can and does result in assignment of unsuitable persons to shipboard berths at a potential risk of causing the ship to be unseaworthy with potential danger for the entire crew, the cargo, and the ship itself.

Insofar as corrective action is concerned for a seaman who has a health problem, the basic requirement before he may receive admission and treatment at marine hospitals operated by the Public Health Service includes a previous 60-day seatime period on a vessel, and application to a hospital within 90 days of being discharged from a vessel. This prior service requirement should be relaxed to the extent of granting admission to any person pursuing a livelihood as a sailor on a regular basis; for example, any person having had sea service within a prior 12-month period should be eligible for admission to a Public Health Service hospital. It would be our further hope that the USPHS would establish a standard for duty fitness for general application to seagoing personnel.

The Maritime industry has made great strides in technological advances both ashore and at sea and it is much overdue that the care and health standards applicable to seagoing personnel responsible for the operation of these new high-speed, technologically advanced vessels be updated and improved.

APPENDIX A

PHYSICAL STANDARDS, SIU-PACIFIC DISTRICT-PMA, SEAMENS MEDICAL CENTER AGREEMENT

PRE-EMPLOYMENT PHYSICAL EXAMINATION FOR SEAMEN (REVISED FEBRUARY 5, 1964)

The following routine plan of examination will be given each seaman.

History

1. Date of birth. Last place of employment.
2. Previous medical history, including injuries, hospitalization with dates if necessary, and will be signed by the applicant certifying that his answers are true and correctly regarded. If he has been under treatment since last voyage by the Public Health Service, he will present a Fit for Duty slip.

General examination

3. X-ray of chest, and of other parts of body if indicated.
4. Blood test.
5. Urinalysis, including sugar and albumin.
6. Candidates in an intoxicated condition will not be examined.

Physical examination

7. A routine physical examination will then be conducted with the candidates stripped, including height, weight, (which should be within 15 percent of normal), blood pressure recorded and special attention paid to the following:

1. Note and record all scars and/or other identification marks.

2. Each eye checked for both vision and color perception (Isochromatic or yarn test).

(a) *A.B., quartermasters, firemen, watertenders, and ordinary seamen*

The applicant must have, either with or without glasses, a least 20/20 vision in one eye, and at least 20/40 vision in the other. Applicants who wear glasses, however, must have at least 20/40 vision in one eye, and at least 20/70 vision in the other, without glasses.

(b) *Other members of the engine department*

Applicants must have, either with or without glasses, at least 20/30 vision in one eye, and at least 20/50 vision in the other. Applicants who wear glasses, however, must be able to pass a test without glasses of at least 20/50 vision in one eye, and at least 20/70 vision in the other. Color vision must be normal.

(c) *Stewards' department*

Applicants must have a minimum vision of 20/100 in each eye; corrected to 20/40 vision in either, with no serious organic disease present.

3. *Ears.*—Check for any evidence of acute or chronic infection or determination of deafness by whispered spoken voice.

4. *Teeth* should be carefully observed for dental caries, pyorrhea, etc., and charted. Applicants should be encouraged to have their teeth checked periodically by a dentist.

5. *Throat.*—Check for enlarged tonsils, laryngits or other abnormalities.

6. *Neck.*—Check for cervical adenitis, thyroid enlargement, etc.

7. *Chest.*—Carefully examine for evidence of tuberculosis, chronic bronchitis, asthma, organic disease of the heart or large arteries.

8. *Abdomen.*—Examine for chronic inflammation of the gastrointestinal tract, hernia inquinal, umbilical, post-operative, femoral.

9. *Skin.*—Check for evidence of jaundice, psoriasis, ring-worm, athlete's foot, eczema, vermin or other abnormalities.

10.—*Varicose Veins,* especially those of the lower extremities and varicose ulcers.

11. Deformities or abnormalities not covered above.

12. Observe mental reaction and evidence of illiteracy.

8. The following conditions absolutely disqualify the applicant for employment, except as provided in Section III(b) of the SIU-Pacific District-PMA Medical Center Agreement.

1. *Mental infirmities.*—Including insanity, idiocy, imbecility, dementia, feeblemindedness, narcotic addiction, or having been committed to an institution for the care of the insane.

2. Diseases of the cerebro-spinal system, epilepsy, chorea; all forms of paralysis, tabes dorsalis, neuralgia, incapacitating speech impediments.

3. *Constitutional diseases.*—Constitutional feebleness, poor physique, impaired general health.

4. Total loss of sight of either eye, regardless of whether or not the eyeball is missing.

5. Cataract.

6. Chest tuberculosis, chronic bronchitis, asthma.

7. Organic diseases of the heart or large arteries.

Blood Pressure.—Candidates under age 30: Systolic, 150 or over; diastolic, 80 or over. Over age 30: Systolic, 160 or over; diastolic, 90 or over.

8. *Amputation* of either hand, foot, leg or arm.

9. *Tumors.*—All types, if malignant.

10. Trachoma.

11. Chronic tropical diseases (yaws-filariasis).

12. *Deafness,* if more than 50 percent in either ear. (a) Otitis media; (b) Perforated drum.

13. Diabetes Mellitus.

14. Fractured skull (depressed, or of such nature subject to easy injury to brain or neurologically symptomatic).

15. Multiple old fracture (pelvis, extremities, spine, etc.) with symptoms or limitation of motion.

16. Ankylosis, or chronic dislocation of joints (sacroilliac, spine, hip, shoulder, etc.).

17. Extensive wounds unless asymptomatic and no limitation of function.

18. Gastric re-section.

9. The following are causes for rejection until corrected, or diagnosis is established:

1. Any acute or chronic disease.

2. Suspected tuberculosis or syphilis in the infectious state; acute or chronic malaria; typhoid carrier, amoebiosis.

3. History of gastric or duodenal ulcer not diagnosed as cured.

4. Osteomyelitis (acute or chronic).

5. *Skin.*—Acute, chronic, contagious and parasitic diseases of the skin; extensive nevi; deep and adherent cicatrices.

6. *Eyes.* (a) Vision not meeting minimal requirements for various departments; (b) color blindness for red, green; (c) conjunctival infections; (d) ulcers of the cornea; (e) tumors of the lids or eyeballs; and (f) injuries to the optic nerve.

7. *Nose and Ears.* (a) Acute or chronic aural or nasal discharge. (b) Mastoiditis, acute or chronic.

8. Throat or mouth infections (pyorrhea, chronic tonsillitis, chronic laryngitis, Vincent's agina).

9. *Teeth.* (a) Multiple cavities and infected roots; (b) *Edentulous*—Plates are required. Sufficient time should be allowed to procure proper dentures.

10. Infection of fingernails (fungus infection).

11. Tropical fevers.

12. Syphilis (in the infectious stage).

13. Gonorrhea.

14. Chancre or chancroid, or any other penile ulcer.

15. Buboes (acute, purulent, inguinal, adenitis).

16. Hydrocele unless asymptomatic.

17. Varicocele unless asymptomatic.

18. *Undescended testicle* (if present in the inguinal canal).

19. *Hernia:* (a) Inguinal; (b) femoral; (c) Umbilical; or (d) Post-operative (each case considered individually).

20. Varicose veins, ulcers.

21. Hemorrhoids—fistula and other abnormalities unless asymptomatic.

22. Tumors—all types, unless benign and asymptomatic.

23. Refusing blood test or vaccination.

10. (a) The above physical standards and qualifications will be strictly adhered to for pre-employment of all new applicants.

(b) The above physical standards and qualifications will be adhered to on all annual physical examinations except as set forth in Section III(b) of the SIU-Pacific District-PMA Medical Center Agreement,

". . . it is understood that "those seamen now established in the industry shall not be deprived of their livelihood by more rigid physical standards than were applied in past years. Consequently, in applying the physical standards of the Medical Center, seamen who have been sailing and who are physically capable of performing the duties of their rating despite the existence of physical defects covered by the more rigid standards of the Medical Center, shall not be denied eligibility to sail because they cannot meet these standards."

(c) Applies to all pre-sign on, sign off or any other examination required.

11. A standard physical examination form will be completed in quadruplicate. One retained by the examiner, the others forwarded to other examining activities as directed.

12. When an applicant is rejected, the cause must be clearly established, and so definitely, as to be conclusive regarding propriety of the rejection.

[Whereupon, at 2 p.m., the committee adjourned, subject to the call of the Chair.]

UNITED STATES PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS AND EXPANDED BENEFICIARY SERVICES

TUESDAY, APRIL 8, 1980

House of Representatives,
Committee on Merchant Marine and Fisheries,
Seattle, Wash.

The committee met, pursuant to notice, at 9:30 a.m., in the U.S. Public Health Service Hospital, 1131 14th Ave., South, Seattle, Wash., Hon. John M. Murphy, chairman, presiding.

Present: Representatives Murphy and Lowry.

Staff present: Peter Kyros, Steve Little, Paris Russell, Taddy McAllister, and Brad Kay, staff of Congressman Lowry.

The Chairman. The committee will come to order. Today we are holding hearings on the U.S. Public Health Service System—the cornerstone of our Nation's obligation to provide care for the U.S. merchant seamen, since 1798.

It is appropriate that this hearing is being held here in Seattle, the port city of the Pacific, because it is home to many of the Public Health Services' primary beneficiaries. This beautiful city is renowned for its excellent Public Health Service Hospital which has provided quality health care to so many in the Pacific Northwest.

I am proud to have with me today Mike Lowry, a member of the Merchant Marine and Fisheries Committee and the Congressman who so expertly represents Seattle and Seattle's interest in the health care of American seamen and other beneficiaries of the Public Health Service system.

This morning it is our intent to explore the changes that may be evolving for the U.S. Public Health Service as it enters a new decade.

We in the Congress have the utmost interest in safeguarding and upholding the Public Health Service (PHS) as a model that provides the best medical care at the lowest reasonable cost. The PHS Hospital and Clinic System is the yardstick by which we can judge the real cost of today's spiraling medical care. It is important to explore the use of the PHS's real cost methodology as a way of struggling with the problems of hospital cost containment and quality medical care as the right of every citizen.

As we try to project an expanded beneficiary base for the PHS Hospitals and Clinics' changing role, it is important that we not lose sight of the congressional intent to maintain a health care system with a capability of serving a unique population group. My concern is that the PHS be able to provide a continuum of care to its statutory beneficiaries as it reaches out to the community's medically underserved.

Ten years ago, Congress made U.S. fishermen, performing seamen's duties, eligible for PHS care. On December 18, 1979, Mr. Lowry and I introduced a bill which will extend coverage to fishermen who have been excluded from PHS care because their particular boat did not gross 5 tons, such as the Northwest's bow pickers or gill netters. This bill would further extend PHS benefits to those who have been traditionally medically underserved: the retired or permanently disabled seaman.

We would like to know whether you think dependents of primary beneficiaries and the medically underserved should be entitled to PHS care. Any extended patient baseload must consider how third party payments will reimburse the PHS system in order that this expansion not add to the public cost of operating these vital institutions.

Last August, the Secretary of the Department of Health, Education, and Welfare (HEW) published a statement on the implementation of the Ad Hoc Advisory Committee's recommendations for the PHS. I want to know how each of these recommendations is being carried out in view of the health system's agency review of the PHS Hospitals' planning process; in light of the fact that HEW has continually forced these hospitals to operate within unrealistic personnel constraints and at funding levels lower than those which many authorities consider adequate for proper health care in the 1980's; and in regard to yet another HEW cost-comparison study which everyone recognizes as one more smokescreen to delay needed funds.

As the Public Health Service enters a new decade with new horizons, it will be the way we manage change in the health care field that will determine our success. As in most areas of human endeavor, change is what is most difficult to handle.

The U.S. Congress is charged with the responsibility for the operation of these hospitals and clinics. We are most eager to hear your testimony so that we can better carry out our congressional duty to see that the PHS manages the changes necessary to provide the best medical care to those so essential to our shipping and military strength.

It is my pleasure to defer, at this time, to my colleague, Congressman Mike Lowry.

Mr. LOWRY. Thank you, Mr. Chairman, I want to, on behalf of the entire State of Washington, and the entire Washington State delegation in the Senate and the House, express our appreciation to you, and your committee and staff, for coming here to meet with us in this very important need.

I believe this is the first time that the chairman of the full Committee on Merchant Marine and Fisheries, as the chairman of the full Committee on Merchant Marine and Fisheries, has given us this pleasure, and it is so important facility which you said from the 1930's, when it first began, it has been the cornerstone of providing needed care for those people that the Public Health Service Hospital statutory must, and should, and it is our responsibility to provide care for. It has also become the cornerstone for very important care for those in the most need in addition in our community, the underserved—the poor. And we are moving into those questions of how we can do that even better, and still meet our responsibilities to serve the seamen, and then, of course, the responsibility for those we have neglected to serve, the retired seamen, the retired fishermen, that are so proud you have joined the sponsorship of, along with Congressman Pritchard, whose staff is represented here, we want to hear about it today.

We really appreciate your taking your Easter break away from New York City, where you have the largest Public Health Service Hospital, I heard you say yesterday; we have, of course, the finest [laughter]—and you come out here and spend it with us.

Thank you.

The Chairman. I may be the first chairman to come out here, but I am not sure that I am the first chairman in an outpatient status, and I hope that we don't get into any patient's status. Of course New York City is undergoing one of its usual traumas right now. There is a transit strike; so it is probably easier to commute from New York to Seattle, than it is to get up from one side of town to the other, these days. Hopefully we will get that situation resolved. It all swings on a 12-percent increase to the transit workers which is less than the rate of inflation, so I guess we will have it resolved soon.

I have always been an admirer of the Public Health Service, its personnel and its facilities, probably because my earliest recollection was passing the famous Public Health Service Hospital, at Clifton, at Staten Island. Like this one, it overlooks a beautiful bay, the narrows and outer bay of New York City. That hospital, and this hospital, cannot be considered alone. These hospitals are part of the Public Health Service System; we would not have the great talent of Dr. Erickson and Dr. Bachman, and other uniformed personnel who are here in the U.S. Public Health Service, if we did not have this hospital system; a system which trains not only the vast range of medical specialties for doctors, but also the related nurse and para-medical services. All of these are integrated into each of the medical community teaching areas. We have striven, during the past 18 years that I have been in the Congress, to further integrate these hospitals within their communities and the medical teaching areas. We have watched over these years, a continuing assault by private medicine on public medicine. If private medicine had its way there would be no Public Health Service; there would be no Uniformed Commissioned Corps doctors, and there would be no yardstick by which to judge medical costs. All medical costs would rise to the highest level of private medicine. I think you and I know what those costs would be. I am a member of the Health Subcommittee in Congress as well as being on the Merchant Marine and Fisheries Committee.

We are so fortunate that Senator Magnuson, over the many, many decades, has represented this State in the Congress. Medical costs span both Public Health and our Merchant Marine. Senator Magnuson was formerly chairman of the Commerce Committee and now is chairman of the Appropriations Committee and ranking member of the Commerce Committee. So we have been able to be joined by Mike Lowry, and other members of the Washington delegation, to try to override Presidential vetoes that have threatened to close these hospitals. We have had to add to the budgets of these hospitals to defense bills so that it would not be vetoed. It is this extent that the Congress has had to go in order to preserve the Public Health Service Hospitals and Clinics, in an effort to preserve the entire Public Health Service System throughout America. It is the Public Health Service which will play an even more expanded and more significant role in the days ahead.

I would like to read a letter from Senator Magnuson that I just received. It says:

> Dear John: Welcome to Seattle, land of salmon—

and I had some last night,

> the Sonics and the Sound. The site of one of our country's most dynamic Public Health Service Hospitals. I am pleased that my home town was selected to host your oversight hearings on the health of American seamen at the Public Health Service Hospital. The PHS operates a health care system that provides comprehensive health service to American seafarers, members on active duty of the Coast Guard, and Commissioned Officers of the Public Health Service, and the National Oceanic and Atmospheric Administration. It is becoming increasingly evident that the USPHS health care system can and should be used in new and innovative ways to improve the access to, and the quality of health services to a much broader population. Recently the PHS has been looking towards long-term planning to insure that the hospitals and clinics address the needs of the surrounding community.
>
> My best to you and those individuals presenting testimony to the Committee today. I urge all of you to keep up the good work and hope you enjoy the visit to God's country.

And it certainly is.

Our first witness today is Dr. James Erickson, and Dr. Leonard Bachman, Department of Health, Education, and Welfare.

Gentlemen, welcome.

STATEMENT OF JAMES H. ERICKSON, M.D., M.P.H., ASSISTANT SURGEON GENERAL, DIRECTOR, BUREAU OF MEDICAL SERVICES, HEALTH SERVICES ADMINISTRATION

Dr. **Erickson**. Mr. Chairman, members of the committee. I am pleased to have this opportunity to discuss with you the Public Health Service Hospitals and Outpatient Clinics. I am accompanied by Dr. Leonard Bachman, the Director of our Division of Hospitals and Clinics.

The eight PHS hospitals and 27 clinics are providing health services to an increasing number of primary and secondary beneficiaries. During fiscal year 1979, a total of more than 500,000 days of care were provided on an inpatient basis, and 1.8 million outpatient visits were provided. For 1980, we anticipate that these figures will be approximately the same. I am pleased to report that the system continues to be in compliance with section 818 of Public Law 93-155.

We are also maintaining our contract care program, through which health care is provided to our beneficiaries by nearly 400 non-Federal health care providers when use of our own personnel and facilities is deemed to be impractical.

As you may remember on June 18, 1979, Dr. George Lythcott and I discussed with you the department's response to the recommendations of the Ad Hoc Advisory Committee on the PHS general hospitals. We reviewed our achievements, the current status, and recommendations concerning the PHS Hospitals, future use and potential role in the community.

Specifically, we focused on the following: First, exploring ways in which the hospitals could help meet the needs of medically underserved residents in their communities; second, developing short and long range plans in conjunction with State and local health planning agencies; and third, changing the overall emphasis of the system to primary and preventive health care. We believe we have made good progress in the past 9 months, and through fiscal year 1981 we will continue to make those improvements. We intend to maintain the current level of operations as required by law, and to be assured of doing so the hospital system has been fully exempted from the governmentwide personnel freeze. The hospitals also have been excluded from the most recent budget cuts.

We have been working toward better integration of the services provided by the PHS Hospitals and those provided through the health delivery systems of their local communities. The mechanisms for achieving this objective are found in the national health planning system, title XV of the PHS Act.

For example, here in Seattle, the local health systems agency has approved a plan calling for continuation of several community-oriented program activities. Section 327(A) of the PHS Act provides the statutory authority for the sharing of PHS medical care facilities and resources. This is done to promote their full utilization on either a reciprocal or a reimbursement basis. In September of 1976 the previous informal affiliation between the Seattle PHS Hospital and 19 community-run clinics was formalized. These clinics provide primary care services to predominantly indigent patients. Nine of them are part of the urban National Health Service Corps project administered through the hospital under an agreement with the PHS regional office. In fiscal year 1979, the hospital provided care to 27,429 people, 16 percent of whom were referred from the community clinics. The hospital also has provided emergency support to the Seattle-King County jail's medical dispensary and obtained NHSC resources for this jail.

In Baltimore the activities of the PHS Hospital focus on delivery of specific components of the overall system rather than attempting to duplicate existing community resources. For example, there has been established a geriatric day treatment center and an alcoholism rehabilitation program. The community services plan of the Baltimore PHS Hospital has been approved by the local health systems agency.

The Boston PHS Hospital is consulting with the local HSA on a plan for full utilization of the facility, following the individual recommendations of the Ad Hoc Committee regarding that hospital. As recently as February 21, 1980, the Acute Care Committee of the Health Planning Council for Greater Boston approved the health plan of the Boston PHS Hospital. The full board approved the plan on March 5, 1980.

Similar progress is being made by the other PHS Hospitals around the country. It should be noted that implementation of these plans involves an ongoing process of review and approval. Although the PHS Hospitals are technically exempt from the jurisdiction of local health systems agencies, it is our policy that, consistent with the Proposed Use of Federal Funds, (PUFF) regulations, capital plans, and services changes will be reviewed by the health systems agencies in communities in which the hospitals are located.

An additional factor is the hospital bed-to-population ratios in cities having PHS Hospitals. Where the ratio is favorable compared to national planning guidelines the HSA's and our regional health administrators will have to assess carefully the responsibilities which the non-Federal health care delivery systems already have before considering possible affiliations.

In accordance with an Ad Hoc Committee recommendation, we have issued guidelines to PHS Hospitals and outpatient clinics to strengthen their Patient Advisory Councils. This will increase both beneficiary and community involvement in care provided by PHS facilities.

The committee also recommended that research and training priorities at PHS Hospitals be consonant with primary care. Therefore, the following actions have been taken.

Each PHS Hospital conducted a thorough evaluation of its graduate medical education program in the context of building primary care and maintaining secondary care capacity.

In connection with this evaluation, clinical programs have been reviewed to determine whether the addition of primary care staff may have lagged behind increases in secondary and tertiary level medical personnel.

Each hospital now attempts to offer one or more residencies related to primary care.

Current expenditures of funds for training integral to residency have been reviewed, and reallocation of resources made, as needed, to primary care programs. Detailed guidance has been issued.

Funds for clinical training outside the service are used principally to build primary care and to maintain secondary care capacity.

A period of field experience for up to 2 years is, in general, required before consideration is given to applicants for post-residency training or fellowship programs in subspecialty areas.

Another committee recommendation called for strengthened organization and management of the PHS Hospitals and Clinic system. In this regard, we are pleased to state that productivity standards to measure cost, clinical effectiveness, and patient acceptability have been adopted. The baseline data and monitoring system has been in operation since October 1, 1979. We are convinced that management initiatives such as these will help to control costs while at the same time improving the quality of the care provided.

We have continued to recruit and develop qualified candidates, which include minorities and women, for top management positions that are or will become available over the next several months. We now have two women hospital directors, one black male hospital director, three women clinic directors, and two other minority male clinic directors.

Before closing, I would like to again mention the 27 freestanding out-patient clinics which are also administered by the BMS Division of Hospitals and Clinics. They represent a significant resource of which we are very proud and feel they will continue to make an important contribution.

Mr. Chairman, I believe that the Public Health Service Hospital and Clinic system, in general, functions very well in service to our primary and secondary beneficiaries. Even during this period of severe economic stress and hardship, we are striving to fulfill our mission and are looking to the future with a view toward performing that mission even better.

Dr. Bachman and I will be happy to answer any questions you might have.

The **Chairman.** Dr. Bachman, do you have a statement?

Dr. **Bachman.** No, I have no additional statements.

The **Chairman.** I would like to make a step-by-step analysis of each recommendation made by your department's Ad Hoc Advisory Committee on Public Health Service Hospitals and Clinics that were not addressed in your testimony.

The Advisory Committee's Report states, and I am quoting, "that absent the data and studies to provide conclusive evidence we nonetheless subscribe generally and empirically to the impression that use of PHS staff and facilities to provide primary and secondary care is less costly than would be the purchase of services in the private sector". I believe that as far back as the Webster Commission study on the PHS your department has analyzed the cost of PHS medical care, and always found it cost effective. Why then does your department still insist on further studies being contracted out on these hospitals and clinics?

Dr. **Erickson.** Mr. Chairman, because I think of the changes in the economic situation, our country, because the last study was done, about 15 years ago, the last large study, the Department felt that it was necessary to have another current study, given the current economic scene, and that study is in progress.

The **Chairman.** You are aware that the deadline is January 1980?

Dr. **Erickson.** I am aware of that.

The **Chairman.** I will quote from a memo that went directly to the Secretary of HEW to undermine this excellent and cost-effective system on January 22 and February 26, 1980. Let me quote from the Assistant Secretary for Management and Budget, Mr. Bohen:

> Decision-making with respect to the future of PHS Hospitals must, in fact, proceed from the inescapable fact that the facilities exist, and that they have underpinnings of support that translates into political strength, at both the community and congressional level . . . the proposal to expand the hospitals to serve the underserved was developed in the context of what to do with these existing facilities, not how best to serve the underserved . . . A subject as politically sensitive and difficult as the future of the Public Health Service Hospitals should not be decided hastily, or in an election year, unless it is absolutely necessary to do so. I do not see any current requirement to make long-term decisions in this area . . . The future of the PHS Hospital should be made the subject of a special policy options study, that would be completed in time for secretarial decision in the fiscal 1982 budget.

Ms. Buto, Deputy Executive Secretary in HEW, continues this onslaught by saying that "the Secretary has reviewed Dr. Richmond's memorandum on the future of PHS Hospitals, and has disapproved the legislative proposal that would amend the PHS Act to authorize the PHS Hospitals and Clinics to serve medically underserved populations." She asked that a policy options study on the future of each individual hospital be presented to her in 90 days so that decisions can be incorporated into the fiscal 1982 budget and legislative processes.

Now you see, we are getting into some deep water. With this kind of attitude, at the very top levels of HEW, and as you pointed out, Dr. Erickson, in your statement, this community transition going on in Boston along with this piecemealing of these hospitals toward a community basis—all this going on without it even being considered at the top echelon of HEW, as a system of hospitals worthy and necessary for the Public Health Service System.

Where does Secretary Harris stand on this issue of further studies and the recommendations to expand the mission of the hospitals by the Ad Hoc Advisory Committee?

Dr. ERICKSON. At the present time, Mr. Chairman, it is my understanding that an in-house review will be done and there will not be the outside consultative review again. Realizing that the Ad Hoc Committee had done that, to the best of my knowledge also, the Secretary has made no final decisions on legislative proposals which you mentioned, to serve the medically underserved. It is still, as I understand, under active consideration in her office, and she has asked for this internal administrative review of the hospitals to assist her in making a decision. No large scale study is envisioned again.

The CHAIRMAN. Let me review some of these studies just lately. A study could be completed in 60 or 90 days. But Secretary Califano commenced a study in October of 1978, he affirmed to me that it was underway in a letter of March 1979. Then Secretary Harris, in her letter to me dated January 20, 1980, said a contract was let in September of 1979. What does all this mean?

Dr. ERICKSON. That's the cost comparative study that you mentioned, yes, I want to make one thing clear, the implementation task force, which was drawn together to review the Ad Hoc Committee's proposals was not another study, that was simply a task force to see how best to implement the Ad Hoc Committee's recommendations. So we have not another study. The last study that was done was the Ad Hoc Committee study. We are following that now.

The CHAIRMAN. That study was to include a request for the necessary funding for renovation and modernization of these hospitals, am I right?

Dr. ERICKSON. Yes.

The CHAIRMAN. When do you think the Congress will get this plan from the Department?

Dr. ERICKSON. I really can't say precisely when, I think it will be sometime this year.

The CHAIRMAN. The advisory report further states, and I am quoting from it, "In the PHS system the Federal Government has the greater assurance of cost control than if a comparable package of benefits were purchased on an entitlement basis, for open-ended use from mainstream medical providers". Isn't this statement assurance enough to your Department that the PHS is not only doing its job, but also stands as a model for "real cost measurement," which your Department should applaud?

Dr. ERICKSON. I think from our perspective, the costs that we engender within the system, have at least in the past been shown to be a fair amount less than the same costs by the private sector, in purchasing certain services.

The **Chairman**. I think that you are familiar with the CHAMPUS program for the Coast Guard?

Dr. **Erickson**. Yes, where all the uniformed services.

The **Chairman**. Didn't CHAMPUS conclude that the purchase cost of medical care in the private sector was far higher than the provision of medical care by the system?

Dr. **Erickson**. I am not sure about that.

The **Chairman**. And didn't it also prove that the medical service was not always available to them, in many instances?

Dr. **Erickson**. That's of course why the CHAMPUS program was set up; for those who were remote from uniform services and facilities.

The **Chairman**. Congressman Lowry?

Mr. **Lowry**. Thank you, gentlemen, for coming out, and for your attention. We spent a lot of time in Washington, D.C., on this. Now there is something that I can't follow I feel that our staff levels are below the load requirements. And I don't understand the staff levels well enough to understand what your statement means when you say that we are going to be meeting the requirements of the law, what is the law?

Dr. **Erickson**. Well, in terms of the law which we are speaking of, is Public Law 93-155, section 818, and the interpretation of that has been that that law required that we keep the same level of services that we had in 1973, we today have more personnel on board, more person years of service being given, than we did in that time.

Mr. **Lowry**. And how did that relate to the patient load in other words, you have that within a formula, a patient load, how do you determine that?

Dr. **Bachman**. I am not that familiar with the area of the law but I am concerned with manpower uses, and developing appropriate manpower particularly in direct patient areas, particularly in the nursing area, and determining exactly how many hours of nursing care are necessary for an in-patient, it is a very controversial subject, in hospital administration. It depends on certain amount of the acuteness of the patients you are taking care of, the length of stay, those hospitals with shorter lengths of stay generally need a higher number of nurses, those with longer, less. And it also depends a lot on the physical plan of the hospital, in order to deal with this issue, which I consider one of the most critical issues facing our system, and three of the hospitals we are having staffing studies done, where we will have one of them is Seattle, one San Francisco, and one Baltimore. We will have a special efficiency expert in the hospital observing the activities, particularly of the nursing staff to determine for that particular hospital what its nursing care needs are, and then we'll have an institution specific standard which we will then live up to.

The **Chairman**. Dr. Erickson, I am going to give you a list of current position needs, at Baltimore, Boston, Nassau Bay, New Orleans, Norfolk, San Francisco, and right here in Seattle, this hospital is short one anesthesiologist and two orthopedic surgeons. Then a second list of the clinics and the recruitment difficulties by area. If you compare this with the level of services provided in the 93d Congress, when the law was established, we would not go below this level of service. In effect this stability was going to require increased funding for this system, in order to maintain that level for obvious reasons. We want also to point out at this time that we have felt that the department requires a hospital, even though it might be my hospital of 600 bed capacity, to be staffed at only 400 beds. Then your department says this is an inadequately used hospital, because it is not up to its full staffing potential. Well, it is pegged down at the 400 level because that's all the staffing there is. So you get a very acute semantics scam coming out of the Department. We, in Congress, have to constantly point out to the Secretary about policy considerations, notwithstanding the overall budgetary performance.

[The following was received for the record:]

Current Position Needs—Division of Hospitals and Clinics Only

Baltimore PHSH.—2 surgeons; 1 Chief of Medicine; and 1 urologist.

Boston PHSH.—1 orthopedic surgeon; 1 surgeon; and 1 radiologist.

Nassau Bay PHSH.—1 internist; 1 radiologist (Chief); 1 surgeon; 1 psychiatrist; and 1 pediatrician.

New Orleans PHSH.—1 allergist; 1 rheumatologist; 1 neurologist; 2 surgeons; 1 gastroenterologist; 1 orthopedic surgeon; 1 dermatologist; 1 OB/GYN; 1 internist; 1 anesthesiologist; 1 OPD physician; and 1 urologist.

Norfolk PHSH.—1 surgeon (Chief); and 1 internist (cardiology or gastroenterology).

San Francisco PHSH.—1 family practitioner with interest in pediatrics; and 1 orthopedic surgeon.

Seattle PUSH.—1 anesthesiologist; 1 ENT; and 2 orthopedic surgeons.

Primary care physicians needed at: Charleston, SC; Chicago, IL; Detroit, MI; Jacksonville, FL; Mobile, AL; Pittsburgh, PA; Port Arthur, TX; Portland, ME; San Diego, CA; San Pedro, CA; Tampa, FL; and Washington, DC.

RECRUITMENT DIFFICULTIES

By specialty

Surgery.
Orthopedic surgery.
Radiology.
Urology.
Anesthesiology.

By location

New Orleans.
Detroit.
Port Arthur.
Buffalo.

INCOME OF PHS PHYSICIANS

A board-certified physician, entering Civil Service at a GS–14 step 1, would get $42,821 in salary. If he was in a specialty which rated a bonus (anesthesiology, general surgery, orthopedic surgery, otolaryngology, pathology, radiology, urology) and signed a two-year contract, he would get another $6,000. In summary, an entering Civil Service physician might get a maximum of $49,000.

A physician entering the Commissioned Corps, boarded or not, would get—if he started at the 0–4 level—$24,430 per year, plus a VIP bonus of $12,500, for a total of $37,000. Non-monetary items (free medical care, non-contributory retirement, etc.) would be added.

Geography does not enter into this.

INCOME FIGURES FOR PRIVATE PHYSICIANS

Average net income from medical practice by specialty (from Profile of Medical Practice 1978, published by Center for Health Services Research and Development, American Medical Association):

AVERAGE NET INCOME

	1974	1975	1976	Extrapolated to 1979
All specialties	$51,997	$56,351	$59,544	$72,900
General practice	44,727	45,410	47,438	51,800
Internal medicine	51,390	56,982	60,459	76,200
Surgery	60,510	68,226	73,245	97,500
Pediatrics	42,112	44,290	46,962	55,100
OB/GYN	61,693	63,316	65,800	73,000
Psychiatry	41,258	44,822	47,565	59,100
Anesthesiology	54,365	57,963	60,059	69,500

I think we want to make a comparison between 1973 and 1980 because there is a glaring shortage. At this time, particularly in Baltimore and New Orleans, we want to get a comparison with the 93d Congress.

Mr. LOWRY. With this nursing study that you are doing, and from what you say, this is a very high priority.

Dr. ERICKSON. Yes.

Mr. LOWRY. I certainly, as a layman, concur with your analysis that that is the most important thing of all the questions. Will that study be able to come directly to us, directly to Congress? In other words, I don't think the Office of Management and Budget ought to be interfering with that study before we get it. If you don't have the money to do what needs to be done.

Dr. BACHMAN. I will forward it that is my responsibility.

Mr. LOWRY. Mr. Chairman, can I make that request at this time that that staff study come directly to us?

Dr. BACHMAN. It will be three hospitals, but we hope and are assuming that the study is successful and the hospitals utilize—then we are going to spread it to the other hospitals, but we have considered this nursing personnel direct care as one of our major problems, and we want to arrive at figures that are really supported by actual studies, and get the personnel for it.

Mr. LOWRY. I am just encouraging you to push that as fast as you can.

Dr. ERICKSON. I would add on some of the specialty issues that Congressman Murphy mentioned. These, as you know, sir, are problems for all of the uniformed services, and to some extent I believe the V.A.—it is just unfortunate that this spread in salaries is so great that certain specialties are hard to come by within any of the uniformed services so that the Public Health Service is certainly not alone in this situation, however, in terms of the services provided for those specialties that we do not have, we see that those services are provided to our statutory beneficiaries, either by consultant coming to us, or by our sending the patient to a consultant, whichever is the the most cost effective and appropriate.

Mr. LOWRY. We just need that information so that we can talk about what the budget priorities are. I really encourage that.

Now a different question, in a different vein, how does the Public Health Service system work with the community HSA? What sort of a working relationship—do you follow the HSA guidelines?

Dr. ERICKSON. I am going to ask Dr. Bachman to go into some of the specifics, but basically they work together in developing long range plans. Now we have informed the local HSA that obviously we run a regionalized system, we are not just like another local community hospital, although we are there to hopefully serve the community, as well as our statutory beneficiaries, so those given we are working to not overdo duplication and that type of thing.

Dr. BACHMAN. I had the opportunity, before I joined the Public Health Service, to watch the development of the HSA system in the State of Pennsylvania, and last year when I joined the Public Health Service, just at the time, in fact the first meeting I attended, was the kick-off of this effort of our hospital federal system to work with a community organization, like HSA. I had grave misgivings of how the relationship would work, because it was a voluntary relationship, it was a relationship in which there was no legal compulsion, and clearly the Federal system, as the Congressman said, we are both a Federal system and we are a community resource, so we are really living in two worlds. Now we've had a year of active process with HSAs all over the country, with eight HSAs, and frankly I think the record has been outstanding. The level of cooperation between our hospitals and the HSAs we have gotten consultation from them, they've helped us create long-range plans and so each hospital now has a long-range plan. In some of the HSAs, where hospitals submitted a long-range plan for review, it was the first long-range plan for many hospitals that HSA had had, in its entire history. And they had to develop their own method of reviewing long-range plans, from the long-range plans that we gave them.

I believe we have good cooperation. Our differences of opinion—there are some, sure. But I believe that the relationship that the hospitals have with the HSAs will ultimately strengthen them, and are in constance of being part of the Federal system, of which I am in charge.

The CHAIRMAN. This is with community clinics, in the community-based systems, obviously this has to be an integrated program, and we have to be a very important part of that program.

Mr. LOWRY. Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Mike. Ought to watch that Staten Island operation with relationship to the HSA's. I keep a liaison there at times. We saw the allocation of a CAT scanner 90 to one area, and we watched that carefully. Then we saw the requests of the ambulance areas exclude the Public Health Hospital.

Dr. BACHMAN. I think New York is going to be the toughest area, a complex area, the Staten Island Subarea Council, my information that there is pretty good cooperation, and the report from the Staten Island Subarea Council, the New York area, the entire HSA of the New York area, have not given our proposals much of a priority as yet.

The CHAIRMAN. We are well aware of that, We talk to Dr. Kavaler, almost on a weekly basis, about that concern. The recent veto of the doctor's special pay, the Uniformed Service Health Professionals Special Pay Act of 1980, what effect does that veto have on the Public Health Service?

Dr. **Erickson**. Well, I believe that if something else like it doesn't happen, we are going to be under the same effect as the other uniformed services. I can't predict precisely what the shortage, if there is going to be one, will be because I think only time will tell. As you know we have lived under annual variable incentive pay renewals, for several years, which have always provided the needed incentives, except for some of those particular specialties, where the range just isn't there. I am just not sure. We are hopeful, of course, that it may include Public Health Service, whatever comes out.

Dr. **Bachman**. I am glad to respond to that. I believe the strength of our system, our full time physicians, and the ability to recruit high quality physicians, that are willing to dedicate their professional lives in this type of work, and if the end result of this legislative process has the Public Health Service physicians in a negative position, that is a poor position, vis-a-vis the Armed Forces, that is going to have a bad effect on the Public Health System.

The **Chairman**. I agree with you, Doctor. Can you tell me the distribution figure between the Uniformed Corps physicians who practice in direct medical care, and those who work primarily in the areas of research?

Dr. **Erickson**. Mr. Chairman, I can't give you any direct comparison, it would be my judgment however, that those who practice medicine certainly in the Public Health Service Hospital and Clinic System, those who actually practice medicine, are far and away, far greater than those who are involved in nothing but research. If you take all the commissioned officers and civil servant physicians, who are at the Public Health Service, I couldn't predict, what difference you would get. But if you look at the care given in programs which are within the Health Service Administration, the American Medical Services, the Indian Health Service, and particularly the National Health Service Corps, which is a large part of the Bureau of Community Health Services, you are going to find practicing physicians way in excess compared to those who are doing research.

The **Chairman**. I have some other questions, which I will submit to you, for the record.

[The following was submitted for the record:]

QUESTIONS TO BE SUBMITTED FOR THE RECORD FOR DR. JAMES H. ERICKSON, U.S. PUBLIC HEALTH SERVICE HOSPITAL AND CLINIC HEARING, APRIL 8, 1980, SEATTLE

Question 1. Why is your Department contracting out more money, time and effort for yet another cost-comparison study when you could use your best efforts to do what the Congress requested in its appropriation's report of June 1979: "The implementation plan (of the Ad Hoc Advisory Committee) is expected to be submitted to the Congress later this year. The plan should include a request for the necessary funding for renovation and modernization of the hospitals to better serve their new role. The committee will reconsider the need for funds to carry out the task force recommendations after the implementation plan is submitted to Congress."

Dr. Erickson, when will your Department submit this plan to Congress?

Answer. Former Secretary Califano had explained the need for assessing whether direct Federal delivery is the most effective way to provide services for merchant seamen in his testimony before the Merchant Marine and Fisheries Committee on September 25, 1978. As stated by Mr. Califano in this testimony, the committee had noted the absence of cost data comparing the direct delivery of such services with purchasing a comparable benefit package in the private sector. Mr. Califano stated he had requested that Dr. Richmond, in collaboration with the Assistant Secretary for Management and Budget, provide him with a comprehensive report of these comparative costs. In a subsequent letter to Mr. Califano from Mr. Murphy it was requested that the findings of this study be made available as soon as possible—implying the committee's interest in these findings.

A study is currently underway to determine these comparative costs and was initiated by this request of Mr. Califano. This study is being performed under contract to ABT Associates, Cambridge, Massachusetts. We would be happy to share the study findings as they become available.

Question 2. The advisory report states that "indeed going into the medical market to try to purchase eligibility for merchant seamen and other PHS beneficiaries would put further inflationary pressure on the whole system". Yet this is just what the Bohen and Buto memo are after. Indeed, your own testimony does not make one reference to the statutory beneficiaries, the seamen and fishermen, yet these hearings are being held in Seattle where so many of these statutory beneficiaries reside. What is the reason for this and please explain how this administration will control spiraling medical costs and balance the budget if we turn these statutory beneficiaries over to the open medical market, which puts a further inflationary pressure on the whole system?

Answer. The current intention of the Administration as reflected in the President's 1981 Budget is to continue operation of the PHS hospital and clinic system while developing plans for its future. As you know, most of the PHS hospitals are located in overbedded areas, so it may be feasible to purchase care in these areas through the private sector without adding to inflationary pressures.

Every reasonable effort is presently being made to provide services to beneficiaries directly through PHS facilities or other Federal facilities where available. In addition, PHS is actively working with GAO and the Federal Health Resources Sharing Committee to increase the percentage of the quantity of services delivered through Federal facilities.

Question 3. The report further warns that: "It is important that the Government honor its obligation by providing sufficient resources to properly serve the patients for whom responsibility has been accepted . . . without dynamic programs . . . as well as other efforts, the hospitals will not be in a competitive position to attract the medical and other staff needed to provide adequate service for even the core patient population seamen."

Dr. Erickson, what is your Department doing in this regard?

Answer. The PHS hospitals have responded to the Ad Hoc Committee Report by developing program and facility plans to meet all committee recommendations in each hospital. Presently, the Secretary of Health and Human Services has requested additional information on each hospital and its plan for local community services. The community services plans are supported by training programs that focus on primary care and health services research to measure and improve delivery systems.

Question 4. The Ad Hoc Advisory Committee's first recommendation stated that "The hospitals should be retained and their mission redefined to reflect the broader missions of the Health Services Administration and the Public Health Service. Specifically, the hospitals should become community resources to increase access to primary health care for underserved populations." You say, however, on page one of your testimony that you are pleased to report that the system continues to be in compliance with section 818 of Public Law 93–155. "Compliance" to me does not contemplate a new mission or implementing the recommendations of the advisory committee. Please explain.

Answer. Compliance means meeting the level of program activity required by Public Law 93–155, section 818. We are complying with Public Law 93–155 while developing plans for the future of the PHS hospital system.

Question 5. The advisory committee's fourth recommendation said: "The recruitment and retention of adequate and competent staff is the most crucial problem facing the hospitals. Implementation of the proposed mission is dependent on the availability of sufficient staff. Appropriate steps must be taken to enhance recruitment efforts. The negative impact of position ceiling must be eliminated." (The hospitals are unable to use resources earned by the hospital to increase staff, and are inhibited in adopting modern staffing patterns which call for greater use of aides and other allied health personnel.)

Dr. Erickson, what is your Department doing in regard to these personnel ceilings?

Answer. We believe that the new bonus authority for civilian physicians, the growing National Health Service Corps, and the new bonus authority for PHS Commissioned Corps physicians recently signed by the President will be adequate to meet PHS recruitment and retention requirements.

Question 6. On page six of your testimony, you state that your Department is maintaining a contract care program, through which health care is provided to beneficiaries by nearly 400 non-Federal health care providers when use of your own personnel and facilities is deemed to be impractical.

Why is this? Is the PHS system overloaded or should your Department be asking Congress for the funds which the House Committee on Appropriations called for in its report to the Congress on June 7, 1979, and to which I previously referred?

Answer. The contract patient care program provides acute medical care to primary beneficiaries in all areas of the country in which there are *no* PHS facilities. Since there are PHS facilities in only 35 cities, the requirement is met through approximately 400 contract providers. The demand for services is limited in some areas making this a cost effective delivery mechanism for nationwide coverage.

Question 7. Recommendation number six of the advisory report says that "The organization and management of the PHS hospital system must be strengthened, with substantial *decentralization* of authority and responsibility for budget and program decisions. Top managerial positions should be staffed by persons who have appropriate training or experience." Would you please comment on this recommendation to "decentralize authority" in light of a February 27, 1980 memo that is signed by you and states that "no organization or staffing realignment or transfer of function may be made without the written approval of the Bureau Director." And in reference to your statement on page five which says that "Another committee recommendation called for strengthened organization and management of the PHS hospital and clinic system." Which one of us is confusing the Ad Hoc Advisory Committee's recommendation and the meaning of "substantial decentralization of authority and responsibility"?

Answer. To strengthen the organization and management of the PHS hospital and clinic system remains an essential objective within the policy of the Bureau of Medical Services.

Hospital and clinic administrators are given and encouraged to exercise responsible discretion to operate effective and efficient organizations. To assist in this effort the Department and Bureau have made available valuable instruments which set forth broad guidance and some general criteria to use in developing the structure of the PHS hospital and clinic organization.

We seek, as one objective, a reasonable standard structure for PHS hospitals and clinics which would serve the primary management purpose of reflecting functional alignment and lines of authority or command. Within such topical uniformity we should then be able to standardize terminology and the placement of functions and departments while recognizing that there will be some variance between facilities.

We have sought to provide a maximum degree of flexibility for management creativity while recognizing the presence of a PHS system which is concerned with a mission of delivering services, and the provision of employment and job rights protection.

Question 8. On page three of your testimony you say that the PHS hospitals are "technically exempt" from the jurisdiction of the local Health Systems Agencies (HSA) and that it is your policy to be consistent with the proposed use of Federal funds regulations, capital plans and services changes will be reviewed by the Health Systems Agencies in communities in which the hospitals are located."

How are the hospitals "technically exempt"? Either they are or they are not exempt. It seems that you are giving the hospitals the worst of both worlds. On one hand, decentralization of authority does contemplate review by HSA and yet your February 27, 1980 memo strengthens the central control of the hospitals on the other side. Doesn't this leave the hospital that thought it would be semi-autonomous on the horns of a dilemma?

Answer. The Health Planning and Resources Development Act exempts Federal facilities from most review processes of health systems agencies.

One of the Ad Hoc Committee's recommendations was that the hospitals should relate closely to local health system agencies and should adhere to the same planning guidelines as those established for private sector hospitals. It should be noted that prior to the above recommendation in response to policy guidance from Health Services Administration, most of the PHS hospitals had established working relationships with local health planning agencies.

Our agreement to submit PHS hospital plans for capital improvements to local health planning agencies for review and comment on a voluntary basis is not related in any manner to any policy regarding decentralization of authority. PHS hospitals are, and remain, a component of the Public Health Service, and, as such, continue to report to those authorities described by statute.

In the final analysis the ultimate test for effective and successful hospital administrators is to develop managerial creativity to operate an efficient hospital program within a Federal system. PHS hospitals unlike the local community hospital have responsibilities that extend regionally and nationally. As such, it is incumbent upon our administrators and managers to reconcile these extra responsibilities. Our most competent administrators do not view such concerns as a dilemma but rather a managerial challenge.

Question 9. What is the effect of the HSA's review on future funding requests for these hospitals and how much relies on the HSA review, given the national nature of the PHS hospitals and clinics?

Answer. We expect the health system agency reviews of PHS hospital requests to consider the national nature of the PHS hospitals and clinics as a critical element in the review process. Other systems of health care include regional centers and regional resources. The health systems agencies must and are developing the capabilities to assess the needs of these facilities in various relationships; local, regional, national. The needs of Federal health care providers as well as the needs of the voluntary proprietary sectors must be understood. PHS as the agency with the responsibility for implementing the health planning legislation has confidence in the abilities of the health systems agencies to develop these skills.

Our first obligation is to serve those segments of the national population that are our legislatively mandated responsibility. The HSA's reviews will present a vital local and regional perspective for incorporation into our planning. It is our intention that the future requests for resources for the system will balance these viewpoints within the overall implementation of Administration policy.

Question 10. Finally, Dr. Erickson, the advisory committee recommended that "dependents of eligible seamen and retired seamen should be permitted to purchase services from PHS hospitals and clinics. HEW should use its authorities to assure appropriate reimbursement from third party payers. Prepayment mechanisms should be explored."

Please comment on this recommendation as well as H.R. 6176, a bill that Mr. Lowry and I introduced in order to implement this recommendation.

Answer. The Administration does not support expansion of the PHS hospital and clinic system to serve dependents of eligible seamen and retired seamen. We are currently reviewing this issue in the context of planning for the future of the PHS hospital system.

The Chairman. Mike, do you have anything else?

Mr. Lowry. No.

The Chairman. Ms. Russell?

Ms. Russell. In addition to the nursing staff study, would you please send to us this inhouse policy study as soon as it is completed?

Dr. Erickson. Yes; we will.

Ms. Russell. Thank you, Mr. Chairman.

The Chairman. Thank you.

Mr. Tom Byers, from the mayor's office, of the city of Seattle.

STATEMENT OF TOM BYERS, MAYOR'S OFFICE, CITY OF SEATTLE

Mr. Byers. Good morning, Mr. Chairman, Mr. Lowry, and distinguished guests. I am Tom Byers, special assistant to Mayor Charles Royer. I have responsibility for health and human resources. I was also a member of the Ad Hoc Task Force on Public Health Service Hospitals, appointed in 1978 by the Secretary of HEW, to recommend options for the future of the PHS hospitals.

On behalf of Mayor Royer, I welcome you to our city, and to the Seattle PHS Hospital.

In the 1930's, the city of Seattle donated this site to the Federal Government so that the Public Health Service could build a hospital to serve the mariners of the Pacific Northwest. Ever since that time this hospital has been a landmark in our city. Like the best of our public institutions, the PHS Hospital has grown with the times. Even though its history has been stormy, with threats of closure during the last decade and chronic shortages of staff, the

Seattle PHS Hospital has endured to become one of this city's most important public resources—a resource our citizens have fought to retain and to build. Our purpose today is to explore with you ways in which that growth can continue.

The legislation you are considering today is a critically important step toward that end. H.R. 6176 would allow the PHS Hospitals the freedom to care for those most in need: the medically underserved. In addition, the legislation will extend coverage to those members of the maritime community who have been excluded in the past by outmoded regulations and bureaucratic redtape. And finally, the bill provides that the hospitals shall have the ability to recover reimbursements from third parties when such coverage is available. As a representative of Mayor Royer, I can assure you that the mayor strongly supports this bill.

I would also like to point out that the U.S. Conference of Mayors has endorsed the expanded mission of the PHS Hospitals among the underserved, and has urged the administration to implement the recommendations of the task force on Public Health Service Hospitals. I would like to submit a copy of that resolution for the record.

Mr. Chairman, it is no secret that our Nation is entering harder times. The Nation's cities are particularly vulnerable to the problems of the economy, because the poor, the elderly, and the working poor have been concentrated in the cities for decades. Health care is one area of the economy where the problems of inflation have been severely felt.

Health care costs now amount to more than 9 percent of our gross national product—$860 for every man, woman, and child in the country—and there is no end in sight to this rate of increase. As health care costs have continued to rise at nearly twice the rate of wages, millions of Americans have simply been priced out of the health care system. This includes an increasing number of elderly, who are theoretically covered by the medicare program, but who lack the funds to pay the deductibles and coinsurance payments. Also included are the working poor—those who work hard all their lives at low wages, but must cut something from the family budget in order to make ends meet. Since basic health care services can be put off more readily than rent payments or the purchase of food, people are forced to go without health services, even though they badly need them. The King County Health Planning Council has estimated that as many as 200,000 people in the Greater Seattle Area may be classified as medically indigent.

In Seattle, the PHS Hospital has been a leader in meeting the needs of these people through its unique relationship with the community clinics. But there is a clear need to mandate this mission for the other PHS Hospitals and to firmly establish this larger mission in legislation.

During our work, the HEW task force visited each of the cities in which the PHS Hospitals are located. In New Orleans, with its staggering poverty and high infant mortality, the PHS Hospital has an obstetrics unit which is underused.

In Norfolk, the task force encountered a large population of migrant workers, largely without health care. This visible need was most ironic to us. The same department which is charged with meeting the needs of these underserved people is the department which operates the PHS Hospitals. It is very difficult to understand why HEW has been so slow in recognizing the potential of these hospitals to meet this larger mission.

H.R. 6176 calls for cutting the redtape to allow the PHS Hospitals to play a larger role in caring for these people. In this way, the hospitals will become an integral part of the mission of the larger Public Health Service among those who most need care. As a member of the task force, I am very pleased that Congress is taking action in the direction we proposed.

I understand that there are some within HEW who doubt that the system of caring for the underserved which has developed in Seattle can be replicated in the other hospitals. I feel they are wrong. While each hospital's efforts to implement the expanded mission will have a different emphasis, I firmly believe each can successfully implement the new mission proposed in this legislation. The Baltimore Hospital is already well on the way toward success. When I visited that hospital 7 weeks ago, I found the hospital moving quickly to expand its service to the low-income communities that surround it. At the same time, the hospital is working with Johns Hopkins University to improve care to the merchant seamen through a unique program for occupational health and safety. The major barrier to carrying out similar programs in all the PHS Hospitals, from my viewpoint, has been the recalcitrance of some officials within HEW.

There are those who will resist implementing this new mission because it will require that the hospitals be given the necessary staff and equipment to play this larger role. They will make the argument in the name of saving money. Their argument brings to mind the image of a man whose wealth is pouring out the holes in his trousers, but who decides to save money by refusing to buy patches. It is time we recognized that expanding the mission and the resources of the PHS Hospitals is a one small way to beat inflation. The Public Health Service Hospitals have a long history of caring for people at costs far below the cost of equivalent care in the private sector.

Using the PHS Hospitals as an integral part of the Federal Government's efforts to aid the underserved will lower the cost of the care provided, and create a means by which to measure the effectiveness of cost containment strategies in all sectors of the health system.

The extension of the hospitals' authority to collect third party reimbursements will strengthen the hospitals at the same time it lowers the cost to these purchasers. In some cases, that will mean a savings to the Government itself, through medicaid and medicare. We have already seen the evidence of these savings in the CHAMPUS program.

In hard times, when the need among the people is the greatest, Government's ability to purchase new tools to meet their need is the most limited. Under these conditions, it makes the best sense to rely on those tools we know we can count on. This legislation was developed in that spirit. The PHS Hospitals have performed their mission well, even under trying circumstances. In our efforts to meet health care needs in the hard times that lie ahead, the

PHS Hospitals are a valuable resource we must use well. This legislation will help achieve that end, and we heartily support it.

The Chairman. Thank you, Tom and I welcome that resolution by the U.S. Mayors Conference in 1979. At this point we will insert the resolution in the record.

[The resolution follows:]

SUPPORT FOR URBAN HEALTH CARE

Whereas, American's cities have large numbers of citizens who face economic, cultural and linguistic barriers in attempting to obtain health care services, and

Whereas, the costs of health care are rising at a rate far exceeding the cost of living and the average increase in wages earned by the American family; and

Whereas, the federal government operates Public Health Service hospitals and clinics and other federal facilities in many American cities; and

Whereas, a special task force appointed by the Secretary of Health, Education and Welfare has recommended that the Public Health Service hospitals should be retained as regional centers for health, and their mission expanded to provide greater assistance to medically underserved populations; and

Whereas, the mayors recognize that coordination between local and federal public health agencies is essential to providing health services to low income citizens with limited government resources; now therefore, be it

Resolved, That the United States Conference of Mayors endorses the recommendations for the Task Force on Public Health Service hospitals insofar as the actions recommended would improve access to health care for urban low income citizens. The Conference calls on the Administration and the Congress to implement the recommendations and make the necessary resources available to the Public Health Service, and be it further

Resolved, That the Conference of Mayors urges the Administration to study the potential for widening the mission of other federal health facilities among the underserved; and be it further

Resolved, That the Administration explore methods for sharing federal resources with urban public hospitals to strengthen their capacity for meeting the urgent needs of urban populations.

Adopted U.S. Conference of Mayors 1979.

The Chairman. Concerning the Ad Hoc Advisory Report to the Secretary of HEW, do you think that the members of the advisory committee were thorough in their investigation of the hospitals?

Mr. Byers. Yes. We visited each hospital and held public hearings, toured the facilities, talked with staff members, I think we were very thorough in our study. It cost the Government a quarter of a million dollars.

The Chairman. Do you think we ought to have more studies, spending more money, in analyzing the same thing over again?

Mr. Byers. I really think that the time for studies is over, and the time for action began about a year and a half ago. One point I did want to address, regarding the most recent cost comparison study, and I believe it was stated that the most recent study of any magnitude was 15 years ago. During our task force review of this issue we did give quite a bit of attention to the Geomet study which was done during the mid-1970's. I don't have the year, but it was a relatively recent study which showed that the PHS Hospitals were able to deliver care at about one-third less than equivalent care in the private sector.

The Chairman. How do you visualize the implementation process in the Ad Hoc Advisory Committee's recommendations?

Mr. Byers. As I understand it, each city, each hospital, was required to come up with a community service plan, and I know that here in Seattle they did that, and it was submitted to the local health systems agency for review. There was a very large and well attended hearing, at which time a great many people commented on the plan and that it was unanimously endorsed, which is actually quite rare in our health systems agency, these days.

The CHAIRMAN. That's rare anywhere.

Mr. BYERS. I think if we went back to those plans, which were developed hospital by hospital, in coordination with the communities we would find things that we could move on immediately. And I don't really understand the need for re-doing that process.

The CHAIRMAN. Congressman Lowry?

Mr. LOWRY. Thank you, Mr. Chairman. In my opinion we are understaffed here now. For the patient load that exists under the existing responsibility. How do we answer the question of meeting the increased staff needs by the greater community involvement of Public Health Service Hospitals. Which I agree we should be doing.

Mr. BYERS. I don't think that there is any question but that the hospitals are understaffed. HEW's own studies show that they are about 15 percent understaffed, but 38 percent understaffed in the critical area of nursing. I think that the Ad Hoc Task Force, when it visited the hospitals, pointed out that that is the most critical problem facing the system.

And in many cases it is not simply a matter of money, it is a matter of staff ceiling, it is the problem of having a limited number of employees that you can hire, so instead of hiring two nurse practitioners, or two nurses, you tend to hire a physician or something else, so that—well, it skews the appropriate balances. So I think one thing we need to address is the issue of staff ceilings, they are probably not appropriate for direct health care programs like the Public Service Hospitals. I also feel that the provision in your bill, which would enable the hospitals to collect reimbursements when they are available, will provide much of the funding that is needed to expand the staff. I think we simply have to eliminate or at least drastically increase the staff ceilings in the hospital in order to get the best economic efficiency from the institutions.

Mr. LOWRY. Have you had experience with any organizations collecting third-party payments. How difficult is that? How does it work? Do we have a big legal staff pursuing third-party payments?

Mr. BYERS. I had a good deal of experience collecting third-party reimbursements. It is very difficult. If you want to raise this issue today, there is someone who can testify today who has experience on this point, Luana Reyes of the Indian Health Board. When they set up the third-party reimbursements systems I think they had experience which is very instructive.

I think we need to be careful that we don't set up a system that discourages the very people we are trying to help from seeking care. I think if we go overboard in trying to recover funds from people who are in this hospital because they don't have money in the first place, we are going to defeat our purpose. But I believe that there are ways with the cooperation of the medicaid program and health care financing administration to recover third-party payments without hurting patients, without slowing these institutions down. It is going to take some help from those people as well.

The CHAIRMAN. As you read H.R. 6176, the bill as introduced, where do you think that added income from the third-party payments would go? How would the hospital be able to avail itself of this money? Isn't there some question on this subject?

Mr. Byers. I think the critical thing is to make sure that the money that the Public Health Service Hospital collect from these sources, stays in the Public Health Service Hospitals, and doesn't wind up in some other element of HEW. The study wing, or something like that.

I think that is critically important, in the past there has been no incentive for the hospitals to collect these third-party reimbursements because the money they collect goes back to the Treasury and there still is difficulty in trying to win an appropriation every year to meet the needs. We've got to keep it in the PHS Hospitals and I think that there ought to be some requirement that it be directed toward the needs of both the legal beneficiaries and the people to whom we are trying to expand the mission of the hospital.

Mr. Lowry Thank you very much.

The Chairman. Thank you very much. Tom, we appreciate your assistance to the PHS over the years and your fine testimony today. [Applause.]

The Chairman. The next panel represents the provider community: Mr. Bill Hogarty, director of the Puget Sound Health Systems Agency, and Dr. Jack Chase, Assistant Dean, University of Washington School of Medicine.

STATEMENT OF WILLIAM R. HOGARTY, EXECUTIVE DIRECTOR, PUGET SOUND HEALTH SYSTEMS AGENCY

Mr. Hogarty. Thank you. Mr. Chairman, Mr. Lowry, it is a pleasure, as well as a privilege to submit some testimony today on behalf of the Puget Sound Health Systems Agency, and I would like to simply summarize the testimony for you here.

The Chairman. Your entire testimony will be included in the record.

Statement of William R. Hogarty, Executive Director, Puget Sound Health Systems Agency

Mr. Chairman and Distinguished Members of the Committee: I appreciate the opportunity to offer some comments today on a subject which has had a high priority with the Puget Sound Health Systems Agency and its predecessors for nearly a decade.

In 1971, when the administration then in office was exploring ways to phase out the eight Public Health Service hospitals, our predecessor Puget Sound Health Planning Council was commissioned by the Department of Health, Education, and Welfare to study the local PHS facility and to develop recommendations to HEW on its future. A committee chaired by Dixy Lee Ray, then Vice President of the Council and now governor of this State, spent a number of months discussing the Seattle facility with those who used it, gathering data and tapping public views through a series of hearings. The committee's findings were that the hospital was meeting critical health care needs which could not be met by other organizations and that its operations should be continued, expanded and improved.

It is fair to say that the committee's conclusions were not exactly what some members of the administration were looking for. It is also accurate to report that the Health Planning Council and its successor, the HSA, have not wavered in their support of the PHS hospital and its programs through the intervening years. The reason for our continued support, beyond the interest and concern of citizen volunteers who *are* the health planning program, is that one of our principal mandates from HEW, which is carrying out the will of the Congress, is to find ways of stretching existing health expenditures to cover unmet needs. There is probably no better example in the United States of a bootstrap, "accomplish a lot with little or nothing" achievement than we can see exemplified right here in this building.

I am sure you will hear testimony from others about services to direct beneficiaries and the hospital's role in medical education, so I will focus my comments on another important and innovative role played by the Seattle facility.

A remarkable thing has happened right here in Seattle. If someone had predicted ten years ago that the PHS hospital would be the center of a comprehensive system of care to medically-indigent citizens, as well as to statutory beneficiaries, he would have been called a dreamer. If that someone had forecast the involvement of some of the city's most prestigious medical institutions in this network of care, he would have been called crazy. Yet that's exactly what has happened. And thanks to the work of some sane, sacrificing people this success has been achieved essentially by getting more mileage from existing physical plants and budgets rather than through grandiose schemes for spending more federal, state or local money.

Beginning in the early 1970s, the Seattle PHS hospital developed relationships with community clinics, sometimes referred to as "free" clinics in their early histories. These clinics, typically started and largely staffed by volunteers, offered health care services in various neighborhoods of Seattle to low income residents who could not obtain the care they needed from established medical sources. Through the sweat and sacrifice of volunteers or dedicated people who accepted minimal salaries, the community clinics grew to the point where they offered an array of primary care services that was remarkably comprehensive considering their constraints and handicaps. The willingness of the PHS hospital to provide to medically indigent patients diagnostic and treatment services which were beyond the capabilities of the community clinics meant that people who were denied access to the established medical care system by lack of funds, language problems or other barriers could receive specialized diagnostic services and inpatient care when they needed them.

The community clinics-PHS hospital network has continued to grow, in the number of patients it reaches and in the comprehensiveness of its services. The assignment of National Health Service Corps personnel to the consortium several years ago increased its capacity and greatly improved continuity of care. Private institutions have now become partners in the effort, providing highly specialized services not available at the PHS hospital. An example of this is the agreement of Virginia Mason Hospital and Clinics, one of the area's most prestigious medical establishments, to provide obstetrical care as well as other highly specialized tertiary services to clinic patients.

In a report issued last year by a special committee set up by former HEW Secretary Califano, the Seattle experience is held up as a national model. The progress made here points to new horizons for public/private cooperation. For example a joint committee of the King County Medical Society, the local health department, our HSA and the community clinics/PHS hospital consortium studied health services at the King County Jail and recommended measures to correct glaring deficiencies. One outcome of this study is a system of providing health personnel for the jail by rotating physicians and other practitioners working in the community clinics/PHS network. The result has been correction of most of the serious deficiencies noted in the report.

As I noted in the beginning of this statement, I felt the best contribuition I could make to your deliberations was to provide some background information on the vital role played by what it is now accurate to describe as the Public Health Service medical center in Seattle. Because this institution has become a true medical center, services to primary and secondary beneficiaries have been improved, as well as those to the medically-indigent.

I think we in this community have proven what local citizens can do to solve a complex set of problems. There are other things that only you and your Congressional colleagues can accomplish. You can remedy the chronic underfunding of this institution to ease the burdens of dedicated personnel who must work in a hospital which has been understaffed for years. You can support and assure passage of proposed legislation which would make service to the medically indigent part of the official mission of these hospitals and make it possible for the institutions to collect reimbursement for services to patients who are eligible for medicaid or other coverage. By taking these actions you will service primary beneficiaries and others who depend on this facility by assuring continuation and improvement of an innovative health care program—one which offers a national example of public/private cooperation and a model for meeting the needs of medically-indigent citizens in a remarkably cost effective way. Thank you.

Mr. HOGARTY. The PHS program has had a high priority with the HSA and its predecessor. I come into this room and I have the feeling a little bit like an American Legion Convention, seeing other people here who share—with whom I have the privilege previously of sharing battles. Although I am not personally effected by these things, I certainly feel the frustration of these folks who are hurt by an opposition to the system. At times trying to do—in the PHS Hospitals seems almost like a hereditary disease among the presidents and secretaries and OMB directors. The first involvement——

The CHAIRMAN. I thought it might be in their oath of office. [Laughter].

Mr. HOGARTY. Our agency's first association with this hospital came almost 10 years ago when the predecessor Puget Sound Health Systems Agency was commissioned by HEW to do a study of this hospital, and advise on its future. The study was carried out under a committee chaired by Dixy Lee Ray, who was then vice president of the council, and of course, now is the Governor of this State.

They spent a number of months discussing the Seattle facility with those who used it, gathering data and tapping public views through a series of hearings. The committee's findings were that the hospital was meeting critical health care needs which could not be met by other organizations and that its operations should be continued, expanded, and improved.

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Thank you.

The CHAIRMAN. Thank you, Mr. Hogarty.

STATEMENT OF JOHN D. CHASE, ASSISTANT DEAN, UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Dr. CHASE. Mr. Chairman, Mr. Lowry, I have submitted my testimony and would like to have that in the record, and simply give you some impromptu comments.

The Chairman. Very well.

Dr. CHASE. My name is Dr. John D. Chase, Associate Dean for Clinical Affairs, School of Medicine, University of Washington, Seattle, Wash.

I appreciate the opportunity of testifying this morning to your committee in support of the U.S. Public Health Service Hospital, a major affiliate of our School of Medicine.

In my opinion this Public Health Service Hospital is a unique institution which fulfills simultaneously a number of important social objectives. It provides exemplary medical care for its primary beneficiaries, it supports the health and medical care needs of community residents who have no other source of care, and it participates in the education and training of health professionals while its staff members conduct biomedical investigation and research assuring that a knowledge base is maintained at the highest level while generating new information to assist people everywhere. All of this is done with dedication and excellence utilizing ingenuity and innovative creativity. In short it is an important element in the societal fabric of this community.

My testimony this morning is focused upon the importance of this hospital to the School of Medicine. Our school began in 1946, and from its inception entered into an affiliate relationship with the U.S. Public Health Service Hospital, and several other institutions in the Seattle area, to develop an educational relationship in support of our objectives while offering the advantages of the academic stimulus to their individual patient care environment. At first this was an absolute necessity from our standpoint, because it was 13 years after the founding of the school before a university hospital could be constructed on the campus and begin operation. While a small university hospital does now exist it is totally inadequate in itself to meet the demands of an expanded student body; not only in medicine but in the other health disciplines as well. Therefore our dependency on our major affiliations, among them this hospital, continues unabated. We view this without dismay and with a sense of rightness because we are convinced that the quality of patient care is enhanced when that care is provided in an environment of teaching and inquiry characteristic of the academic milieu. Therefore by such affiliation the influence of the medical school can be broadened beyond the primary goal of the education and training of physicians. In that context this Public Health Hospital offers the School of Medicine an important base upon which its objectives can be met, while the partnership brings very real benefits to the patients cared for by the hospital. In this regard permit me to cite a few statistics. Our medical school class numbers 175 students, 36 of these students receive their third year experience in medicine, and 30 in surgery at this hospital, 16 second year students complete the introduction to medicine, plus additional special experiences are offered to the fourth year student in otolaryngology, cardiology and gynecology. In addition 40 graduate physicians, 16 percent of the total, are trained in a variety of specialties.

The statistics alone do not paint the entire picture. As I am sure you are well aware the number of physicians being trained today is being questioned. Under more intense scrutiny is the critical issue of the geographic and specialty distribution of the physician who is entering practice. Our school has approached this in an anticipatory fashion and 12 years ago revised its curriculum to provide an increasing emphasis on primary care, while continuing to maintain its very strong base in research and clinical investigation of the more sophisticated modalities and mechanisms of care. Nine years ago it formed one of the earliest departments of family medicine, and 8 years ago committed itself to a regionalized program of medical education to encompass the four Northwest States. At each step the Public Health Service Hospital participated in these discussions, and where possible became involved in support of these new ventures. Most significantly it has made available, through its own basic philosophy, a role model for continuity of patient care. This hospital's deep commitment to provide primary care which is high in quality and tailored to meet the emotional and physical needs of its patients while recognizing the uniqueness of the individual is an exemplary role model, for not only students but other institutions in this community.

It is this compassionate attention to the individual and the willingness to assume a continuing obligation for the individual that proves the example to which we wish to expose the future physician who has elected to become the primary care physician of the future.

That this effort has been successful is measured by the acceptance of this model by our students. Two weeks ago the results of our senior students career choices became known. Over one-third of all of our students that will graduate in June have elected to undertake advanced training in family medicine, and over one-half will be entering one of the three primary care specialties. I have dwelt on this both because of its importance, and because I am convinced that if it were not for the U.S. Public Health Service Hospital our track record would not be as good.

Finally I would like to comment upon another aspect of this hospital's complex and important community relationship. While it does not bear directly upon the medical school's primary obligation it is singular as an example of this hospital's role in this community. I refer to the creative way in which the hospital has developed patient care relationships with other Federal health care facilities, other public hospitals, and the private sector not-for-profit hospitals. This hospital has recognized the importance of doing well what it can do best and developing relationships with these other institutions to meet the needs of its patients when by doing so it assures high level care while conserving resources. In my experience such enlightened management should be recognized and complimented.

Now we have had a very close relationship with this institution and it continues today. The hospital here has been in our overall program and the record will demonstrate that, I think, quite abundantly. It is an important aspect of the spectrum of our education for several important reasons, one of which is quite clearly the changing direction of our school to emphasize the education of the physician and other health care personnel in the primary care discipline.

This hospital is an important key in our ability to provide that kind of education experience.

Any partnership, of course, to be effective must be of benefit to both partners. We are convinced that our relationship with the Public Health Service Hospital has provided benefits to the beneficiaries of the hospital and its patients, inpatients and outpatients, because of the academic status of the school with the hospital. This means faculty and students, in the direct interaction of patient care, caring within a spirit of inquiry, which we feel does influence the level of care and quality of care that is provided.

And second, the hospital's recent quite innovative move to provide care to the community, those who have no resources for care otherwise, has made an important element from our perspective in the education curriculum, in that this comprehensiveness of care which can be provided underpins of course the basic concepts of primary care.

The third point I would like to make is one which I admire the hospitals movement toward and that it is sharing its resources with the community from the standpoint of working out arrangements with other institutions in the community, in order not only to conserve its resources, but to provide a broader spectrum of care for its patients, and those modalities of care are not available within the hospital itself.

Just this morning I was speaking with Dr. Bachman, and each of us were talking about the recent innovative change in providing neurosurgery to beneficiaries of this hospital which is now being provided by the VA hospital, and other hospitals on a cost reversible basis, which means that the resources available in one institution can cover a spectrum of patients that the two institutions, each institution profiting, thereby, and most importantly, the patients getting the benefits from such an arrangement.

I think that is a model which could well stand inspection for replication elsewhere.

With those few comments, Mr. Chairman, I would close my extemporaneous comments, and be glad to answer any questions that you would ask.

The CHAIRMAN. Thank you, Dr. Chase.

Mr. Hogarty, as the relationship between the Public Health Service providers and consumers may be changing, how do you think the HSA will view the PHS system relative to cost control, and medical care for the indigent and underserved minorities?

Mr. HOGARTY. I think, as was noted earlier, the HSA local agencies did review and strongly endorse the long-range plan of the hospital and particularly one feature of that plan, that is the effort to reach out into a larger part of the Northwest Washington area that we serve with some of its programs. I think that the HSA views this as a very cost effective program, and as I mentioned in my testimony, one that really rides piggy-back, if you will, on some statutory expenditures, stretches those a little bit in order to cover the needs of people whose needs can't be met any other way.

The CHAIRMAN. I noticed on that bronze plaque downstairs, and also on the opening statements, that the city of Seattle gave this land to the Federal Government to build this hospital. Now we see, over the last decade, the Federal Government trying to give back the whole kit and caboodle to the community. It has been a part of the thrust of HEW over these years to do that. What would be the effect if this hospital and its facilities were turned back to the city or to some other operating entity such as the University of Washington?

Mr. HOGARTY. Almost 10 years ago our predecessor agency did this report at the request of HEW, the Dixy Lee Ray report. One of the features of this report was an investigation of possible alternative uses of the hospital and possible alternative operators of the hospital. There were only two potential—well, I guess I could use the word conceivable operators that were identified. One was a group of osteopaths, who had some ideas of turning this into an osteopathic medical center and medical school. I don't believe that proposal was ever reduced to writing. There was a proposal that the University of Washington, and there was serious consideration by the university at that time, mainly to protect some of the programs that Dr. Chase has talked about. It isn't that the university wanted it, but it was so important to them that if we had to—well, if there was no other way, perhaps they could take it over.

Eventually, the university decided that it simply would not be feasible. I really don't see, having viewed this scene here for 10 years, I don't see any organization that will come in and take over this hospital.

The CHAIRMAN. In this territory?

Mr. HOGARTY. In this territory.

The CHAIRMAN. Dr. Chase, would you like to comment?

Dr. CHASE. I would like to suggest that the city, or some entity within the city, assume the responsibility begs the issue of the area this hospital is responsible for, that goes up into Alaska and a number of States. It would be difficult to conceive that a local entity would be willing to assume that kind of obligation.

The CHAIRMAN. We found the same thing in New York, that there really was no entity capable of taking over the operation of the hospital and still provide care at the levels of expertise that we expect and are getting from our Public Health Service Hospital.

Mr. LOWRY. Bill, what is your estimate on the cost effectiveness of delivery of the Public Health Service Hospital Systems?

Mr. HOGARTY. All of the figures I have seen indicate that the cost of given quality care here is less than any private system. I think right now it is perhaps a little too cost effective because of reduced staffing, and I hope in fact that you will make it a little less cost effective in that sense. Everything that I have seen indicates that it is a very cost effective operation, and less costly I should say than the private service system.

Mr. LOWRY. What has been the inflation effect on health care in the last few years in this country?

Mr. HOGARTY. Usually up to twice the inflation rate for the other items in the consumer price index.

Mr. LOWRY. Do you have an observation then of where we should be spending money?

Mr. HOGARTY. Where we should be spending money?

Mr. LOWRY. As a Government budget priority concerned with doing something about inflation?

Mr. HOGARTY. Yes, no question. One of the priorities would be that, and if it is to restrain the inflation of health care costs.

Mr. LOWRY. Dr. Chase, you sort of answered the one question I wanted to ask, our medical school's regional facility also, could you give a little description of the service, more primarily our graduate school, going out into the service of the community?

Dr. CHASE. Yes, as your question indicates, the school accepted the institutional responsibility for the education of physicians for the four-State area, Alaska, Washington, Montana, and Idaho. We have 175 students which enter each year in the class, 50 of those positions are set aside for the citizens of those 3 other States. We have tracked very carefully where those students are going, and I am proud to be able to tell you that this program has been effective in the increasing location of choice, of students back into those States. I am not so proud to be able to tell you that as we examine Alaska, Montana, and Idaho, there still is a very low rate of population/physician ratio in those three States so the job still is continuing; there is much more to be done.

The last point I would like to make is that as indicated in my earlier comments, in 1968 the school arranged the curriculum to emphasize training in primary care. This was prior to the time that much of the public debate was generated about primary care. Just 2 weeks ago we received the career choice, the selections of our graduating class, that graduated in June. A third of that class has selected family medicine as their future career goal and over one-half of the class has selected one of the three primary care specialties, that is family medicine, internal medicine, pediatrics. The program in short has been successful.

Mr. LOWRY. We are very proud of our medical school and our health system here, in this hospital. Then I believe the point of necessity of this institution as a training base—I might have picked the wrong term, but as a regional institution, is very important.

Dr. CHASE. You picked the right term and it is important, there is no question about it. As I've tried to say earlier, it is critical to the successful strategy for the development of education for students in this area.

Mr. LOWRY. At least in the four-State area.

Dr. CHASE. Yes.

Mr. LOWRY. Thank you very much.

The CHAIRMAN. Thank you very much.

Our next panel is composed of representatives of the PHS statutory beneficiaries; Mr. Lincoln Denny, representing seamen, and Katherine "Tink" Mosness, representing the fishermen.

STATEMENT OF LINCOLN D. DENNY, MARITIME TRADES DEPARTMENT, AFL-CIO, SEATTLE, WASH., PUGET SOUND DISTRICT COUNCIL

Mr. DENNY. Mr. Chairman, Congressman Lowry, and guests. My name is Lincoln Denny, and as the spokesman for the maritime employees represented by the Puget Sound region of the Maritime Trades Department on health care matters in regards to the U.S. Public Health care facilities in this area, and as an authorized delegate to the Patient Advisory Council of the Seattle Public Health Hospital, I would like to address this committee on some of the concerns regarding medical care for American seamen both active and retired.

An amendment to the Public Health Service Act has been presented to the 96th Congress through this committee, which would extend medical care to active seamen's dependents as well as to retired seamen and their dependents, dependents of deceased seamen, as well as certain fishermen not now receiving these benefits.

Past legislation has recognized the Government's responsibility to provide care for active maritime personnel and extending this service to cover the above would enhance the care available by providing a broader base of patient load to more effectively utilize the teaching potential now available in most public health care facilities.

To qualify for retirement, the maritime employee must spend his most productive years in a working environment that is unique in its requirements, and that exposes these employees to hazards and health situations found in no other industry. To include dependents is simply a matter of extending the modern concepts of medicine, which advocates family-oriented medical care as the most reasonable and economic financial level.

There is little or no real medical protection available to the American seaman and his dependents after retirement and in the case of the unorganized, which makes up a large portion of the maritime work force, there are no medical benefits or retirement moneys other than social security.

In this industry the age of retirement is most often below that which the retired person is eligible for the present medicare provisions.

Recognizing that there are limited third-party-payment possibilities in some cases, we agree that these payments should be used to help defray some of the costs, as long as the lack of such coverage does not affect those who were not covered. We believe that the care available should be extended to all and should include the necessary treatment that insures complete medical service presently furnished active seamen.

I also believe this committee should recognize the need for removing the ceiling on the hiring of medical care personnel. A minimum standard should be mandated so that the level of nursing care, support staff, and others in the service delivery area of care would be adequate by standards recognized in the private sector to properly staff a facility of any given number of beds.

The Maritime Trades Department would also endorse legislation that would make the Patient Advisory Council of the Public Health Hospitals a congressional mandate, rather than an administrative whim of the Secretary and depending solely on those persons who are willing or able to donate their time. The PAC in this hospital has been the motivating factor in promoting expedited care for active seamen, reducing time loss, which is beneficial not only to the seaman but to his employer, in promoting other areas of care that has not only been a benefit to the primary beneficiaries but to the community as a whole, and addressing problems that arise that affect patient care and to satisfactorily solve some of the concerns of both the patients and the staff.

Last but not least, we wish to endorse the concept of extending beneficiary status to others in the community who have little or no recourse to medical care. This is done not only from a humanitarian standpoint, but for the need to continue the patient load in a degree that would insure space and medical care that would be necessary in the event of a national emergency. [Applause].

The CHAIRMAN. Thank you. Ms. Mosness?

STATEMENT OF KATHERINE MOSNESS, REPRESENTATIVE FOR FISHERMEN ON THE PUBLIC HEALTH HOSPITAL CARE COALITION AND THE PATIENT ADVISORY COUNCIL OF THE PUBLIC HEALTH SERVICE HOSPITAL

Ms. MOSNESS. Mr. Murphy and Mr. Lowry, members of the committee, thank you for the opportunity to be heard today. My name is Katherine Mosness, I am the fisheries representative on the Public Health Care Coalition and the Patient Advisory Council of the Public Health Hospital, and I am the Health and Safety Chairman of the Washington Association for Fisheries.

As the maritime people and the fisheries people, having many of the same problems, I heartily endorse the statement Mr. Denny just gave.

When the invitation came from your committee, Mr. Murphy, asking me to speak before this group, they suggested my remarks be limited to 5 minutes. It would be easier to use 25 minutes, but I will try.

Eight years ago the Public Health Hospital here in Seattle was about to be closed. As the executive officers of the National Federation of Fishermen here in Seattle, it was my job to express the policy of the federation and to stand firm against its closure. There had been so many staff cuts, tight money for operation of the hospital, and in general, lack of upkeep and repair, the facility was really in pretty bad shape. It did not compare favorably to the other hospitals in the vicinity. In other words, it was not used by fishermen from choice but from necessity.

After that hearing a group of concerned people had a meeting regarding the hospital. I was invited to that meeting and what took place in that room that very first night completely changed my whole thinking about the hospital. These people were not satisfied with the hospital, either, but they were rolling up their sleeves to do something constructive about it. These people were not discouraged. These people were positive. It was their hospital and they were going to make this facility into a hospital that they could be proud of. Each person there represented a different beneficiary group, but they had one thought—to get together and to get this hospital back on its feet again.

After writing many proposals, sending out many mailings, of which they have always raised even their own money for paper, printing, and postage, things started to be turned around. After many protests and news media oriented events encouragement came slowly. Nothing tangible at first. Just a different feeling of the hospital than they had before. The hospital employees felt someone cared about them. The fishermen began to feel differently about the hospital. They became more optimistic, started to become involved in letter writing to the congressional delegation, handing out information, and in general had the hope some day their hospitals would be OK again.

In those days we had Senator Magnuson. It was the Senator who had enough foresight to keep this facility open and funded. It was Congressman Pelly and Congressman Meeds in whose district the main part of the fishing fleet lived and who were the most concerned with the fishermen's plight. Really, not many others cared. This group back there continued to work and the group which now had the name of Public Health Care Coalition, continued to work out here.

Understaffing and underfunding continued to plague the hospital. Our fishermen would come in from a trip, go to the hospital, not be able to make an appointment for sometimes 2 or 3 weeks down the road, be out on the fishing grounds at the same time they did have the appointment, and miss their appointment, and the cycle would start again. Rumblings were heard often from that problem.

May I quote briefly from my testimony before this committee on March 17, 1978:

> As this hospital serves the states of Washington, Oregon and Alaska, so many of our fishermen have tried at one time or another to use this facility. If you had an opportunity to talk directly to them, you probably would not like the stories they have to tell about trying to get appointments and care.

Since that time however, this problem has changed a great deal. By taking preregistration forms to the various organizations, and by upgrading of the appointment system, this problem seems to have been taken care of. There is a different feeling about the hospital now. Yes, of course we are still understaffed and underfunded. We do have regular meetings with our congressional delegation. We feel certain that Senator Magnuson, Congressman Pritchard, Congressman Swift, Congressman Dicks, Congressman Lowry, understand the importance of this hospital facility to the fishermen as a beneficiary group, and to the other beneficiary groups and the community as a whole. We have shown that the Public Health Hospital is able to provide quality health care at a cost far below the private sector. Good health care at a very reasonable price is what it is all about, isn't it? We think so.

In a recent newsletter from the Puget Sound Gillnetters Association, March 1980 issue, quote:

The Council (U.S.P.H.C. Coalition) meets on a monthly basis and discusses such pertinent items as adequacy of nursing staff, hospital grounds hazards, patient benefit funds, just to name a few, and certainly watchdogs Federal legislation that could affect fishermen's use of this vital facility. The hospital is an important place in this community, even if you don't think you will ever have need for it. I for one go on record of appreciating this group's (Coalition) service and I have needed this hospital facility twice. It happens, and it is gratifying to know it is there. Phil Sutherland, President.

I have two brief items of "housekeeping," one is an amendment to H.R. 6176, regarding the eligibility of seamen:

Section 249 of the Public Health Service Code. Subtitle 1. Changed to or licensed under than—-

Justification: The eligibility of fishermen as beneficiary of the U.S. public health hospital should be based on the dependency of fishing as a basis of livelihood, rather than the size of the vessel used in fishing.

To qualify for Public Health Hospital care, a fisherman must have a documented vessel. A documented vessel must be registered as over 5-ton-gross. Why is one that is only 4¾-tons gross denied coverage? As this is only a minor change, we feel that there should be no opposition, to this proposed change.

Also, we feel the families of the fishermen should be included as beneficiaries with health care, if they need it. If these families have insurance, third-party payments could help pay for this; if not, care should be provided for them.

We are also very happy to have the long awaited north district office of the Seattle-King County Department of Public Health open. That will take a large load off of the main hospital facility and expedite our peoples' appointment scheduling. We commend all of those that have worked on this long needed facility.

Two years ago I spoke before the Valley Christian High School in Brownsville, Tex. I told them that although we get upset at our Government at regular intervals, democracy does work. I told them how one arm of the Government is an austerity move, wanted to close down our hospital and we felt very strongly this facility was our right and we fought for it and now we have a facility we are proud of. How a small group of people, working together for 8 years, made up of Japanese, Indian, black, white, old, young, Christian and Jew—each representing their own beneficiary group, working with their congressional delegation, not only could, but did, save a hospital.

Our sleeves are still rolled up. We are still working to continue to upgrade our facility. We have made a great deal of progress, but we continue to need your help, and your support.

And we support H.R. 6176. Thank you. [Applause.]

The CHAIRMAN. At this point we are going to place in the record a statement by Mr. Steve Troy, the west coast representative of the Seafarers International Union.

STATEMENT OF STEVE TROY, WEST COAST REPRESENTATIVE OF THE SEAFARERS INTERNATIONAL UNION, AGLIWD

Mr. TROY. My name is Steve Troy. I am west coast representative of the Seafarers International Union, AGLIWD, representing our membership in the States of California, Hawaii, Oregon, Alaska, and Washington.

We appreciate the opportunity to testify before you today regarding the U.S. Public Health Service (PHS) Hospital System and the health care accorded U.S. seamen and other statutory beneficiaries. At the outset, we wish to reiterate and reaffirm our support for this system of hospitals, clinics, and staff which readily administers the medical needs of a unique segment of U.S. citizens.

In the long fight to maintain a system of quality medical care for seamen, a struggle which is in its fourth decade and which has encompassed six succeeding administrations, the SIU and affiliated organizations have appeared countless times before this committee and many others.

We again commend this committee for its continued initiative in holding oversight hearings to preserve a strong modern Public Health Service Hospital System that will in the end benefit the entire Nation.

We are convinced that the U.S. merchant seamen must continue to have a special system of medical care in order to maintain their ability to serve the distinctive needs of a peacetime merchant marine and to keep U.S. seamen in readiness should an emergency arise.

The American seaman has always had unique health problems. He is at sea for long periods of time, during which, with few exceptions, the only medical care available to him is first aid. Comprehensive treatment of illnesses and injuries must often be deferred until the return to homeport.

This care must be immediately available, even for ailments which for the rest of the population are less demanding. To avoid loss of employment, and income, a seaman needs to get into the hospital promptly so he can be out in time for the earliest possible sailing. This time pressure increases as U.S. merchant vessels, as a result of technological innovations, spend less and less time in port.

The availability of top-quality medical care on a priority basis in Public Health Service Hospitals has made the American merchant sailor the healthiest and most productive in the world, qualities whose preservation is vital to the success of the Nation's maritime program.

Although we remain steadfast in our position that the key consideration in maintaining a strong Public Health Service Hospital System be priority and quality medical care for seamen and other primary and secondary beneficiaries, we also believe that the system must become a leader in the expansion of health care for all Americans. In this respect, we support congressional initiatives which would unequivocally retain, expand, improve, and integrate into local communities the Public Health Service Hospital System, maintaining Federal control. In this way, the United States will continue to observe its 200-year commitment of providing medical facilities and staff necessary to maintain priority health and welfare care to American merchant seamen. In addition, integration into local communities under Federal control would broaden the health care services of the Public Health Service Hospitals and Clinics to many needy and medically underserved Americans.

At this point we would like to reaffiim our opposition to any attempt to transfer U.S. Public Health Service Hospitals to community control. We are greatly concerned with the effect community takeover would have on patient care for the primary beneficiaries of the hospital service. The American seaman, as I said before, is a unique patient. He needs priority service without delay and we feel that community control ultimately will result in diminishing that priority attention.

We do not mean to imply that local groups would operate the hospital with a lack of humanitarian understanding. The fact is, however, that a seaman in a strange port is a man without a hometown. Without a Public Health Service facility, he becomes virtually a medical indigent. He looks to a PHS health station for immediate treatment because many times his layover is short. He cannot bear the economic hardship of being delayed for excessive periods of time because of the inaccessibility of a facility not under direct Federal control.

The Seafarers International Union is deeply committed to the preservation of the Public Health Service Hospital System. These hospitals consistently provide excellent health care benefits to seamen, fishermen, Government employees, and community citizens alike. Because of frequent attempts by past administrations to close the hospitals or transfer them to community control, the SIU, in conjunction with congressional committees such as this, has had to fight to maintain the existing system while trying to accomplish major steps to renovate hospitals and add needed staff and services. The role of PHS Hospitals must be expanded and new funds for modernization, improvement, and new equipment be infused into the system. In this way the hospitals can serve as models for the national health care program.

We again wish to express our appreciation to the committee for their continued support and interest in the Public Health Service Hospital System and the medical needs of American seamen.

The **Chairman**. Mr. Denny, do you see any conflict between primary beneficiaries and other patients cared for by the PHS, given its expanded mission?

Mr. **Denny**. No, I don't. When you say "conflict" I don't really understand what you mean.

The **Chairman**. We are talking about the apportionment of many new fishermen beneficiaries. Are we overloading these facilities in a way that we cannot provide priority care to seamen?

Mr. **Denny**. What I have found, you take the seaman, you have a peculiar problem in the transportation of cargo on modern vessels. The turnaround time is very short. Eight hours, sometimes less. And we did run across the problem of the ill seaman being able to leave that ship and come into the hospital, getting adequate information as to whether he was fit or unfit for duty, and reporting to the master on that vessel whether or not he is going to be able to make the sailing time. Through the Patient's Advisory Council, the administration of this hospital, we worked out a system whereas these persons make a preappointment and are taken care of when they come into the hospital, and the determination is made whether or not they are fit or unfit for duty, and this can then be relayed to the union hall to replace the man if it is necessary.

You've got to understand, if a seaman misses his vessel it may be 3 or 4 months again before he is reemployed, taking into consideration the ship being as it is now, with the American-flag vessels. The only problem we ran across is relating this to some of the other beneficiary groups that we weren't asking for preferential care or treatment, we were asking them to consider the unusual circumstances, and generally speaking those other beneficiary groups accepted that. We also recognize that with the fewer number of maritime employees, in order to keep this facility open, it is necessary to have these other beneficiary groups and their benefits to the seaman and to the fisherman. Because with that added, that workload, we can take better advantage of the University of Washington's teaching facilities, we just really don't find any conflict in that area. There are still some problems we will have to work out, through the administration and the advisory council, and it certainly is working out very well. The beneficiary groups are very supportive and we are supportive of them.

The **CHAIRMAN**. You are being too congratulatory to get the message across, but the primary beneficiary should have priority treatment particularly when he has a ship to meet.

Mr. **DENNY**. Right.

The **CHAIRMAN**. Ms. Mosness, how many fishermen will be affected by H.R. 6176, which will eliminate the 5-ton-vessel criteria?

Ms. **MOSNESS**. Not very many. It is a group that have been excluded, its smaller gillnetter vessels, I think it would take in the reefnetters, not percentage wise, it would not be that large a group, but it was just something we felt should be buttoned up, that it was discriminatory.

The **CHAIRMAN**. 200?

Ms. **MOSNESS**. More than that, probably. Just pulling a number out of the air, I would say 1,000.

The **CHAIRMAN**. Where do they now receive care?

Ms. **MOSNESS**. They don't.

The **CHAIRMAN**. What is their average income?

Ms. **MOSNESS**. If they are full-time fishermen, there are some fisheries that it is advantageous to have the smaller boats, if they are full-time fishermen, in the State of Washington, or the State of Alaska, or the State of Oregon, there is a great range, of income, if they are in salmon which most of the smaller boats would be, the season is short. But if they still maintain the bulk of their livelihood from that we feel they should be covered. Maybe a longer season for salmon.

The **CHAIRMAN**. One of your concerns, already provided for by the Lowry bill, is that we strike out "and license" and add "or licensed."

Ms. **MOSNESS**. Yes, I support him and we are happy to have him.

Mr. **LOWRY**. Thank you. Mr. Chairman, I want to thank the staff who did the work of putting together the Lowry bill, it is really the Murphy-Lowry-Pritchard bill. [Laughter.]

They really did good work, and I when reading it, thought we had taken care of it. I don't have any questions. You've both made statements that are absolutely accurate.

Mr. **DENNY**. May I say one thing more. The area of retired persons may be affected in this area for this hospital alone, would amount to a ball park figure of 1,745. That are retired in this area, and would directly affect this hospital.

The **CHAIRMAN**. And spouses?

Mr. **Denny**. That is only the retired personnel, that does not include families, I have no idea, unless we use an average family figure for that.

Mr. **Basbourg**. My name is Paul Basbourg. I retired in July. This 90-day rule, that you keep your eligibility going, you've got to come in every 90 days to the hospital to keep the eligibility going. Whether there is something wrong with you or not. Of course, there is with me, because I had a heart attack in October, but I think it is wasting the staff time, and the doctor's time, you should be eligible regardless. This 90 days—it is stupid to have a man come in and take somebody's time, the doctor's time, when there is nothing wrong with him, in order to keep his eligibility going. I spent 36 years at sea, and I think my eligibility should keep going and going, as a retired seaman, without taking up the hospital's time.

When I went to sea I never come into the hospital unless there was something drastically wrong with me, and that is all I wanted to ask about—that 90 days. To keep your eligibility going, I thank you.

The **Chairman**. Counsel?

Mr. **Little**. You indicated that a maritime employee is exposed to hazards and health situations found in no other industry. Would you briefly describe what you meant by that?

Mr. **Denny**. Yes, I would say that in the event that a seaman leaving port comes down with an illness while the vessel is at sea, with the limited medical facilities available, aboard any ship, the degree of that illness may progress to a point that when he gets to the next port of call, he has contracted something that may necessitate continued treatment over a long period of time, where if he had access to immediate medical care, that probably wouldn't be a problem. There are areas of the world which they go into that maybe a seaman is exposed to tuberculosis more, say, than he would be in this area, in the Orient, in the Near East and the Far East, those kind of things. And the length of time that that seaman is aboard that vessel prior to getting back and having that care can be a very serious factor, in the seriousness of the illness. Those kinds of things over a period of 30 years, 35 years, when a man goes to sea, build up.

Another thing, when the seaman gets into port, if there is no—or if he is ill, and there has been no appointment situation, the master may send, or may say "well, go up to the hospital and see what the dickens is wrong with you, and then let us know if you are going to be aboard or not."

Prior to our preappointment commitment the seaman sometimes would come up here, and maybe several hours prior to his being acknowledged, then he goes through a preliminary medical examination by this time he has got to get back to the ship, and they may send him up to the second floor, for X-rays, and he has to make it back to the ship because he doesn't want to lose his job. He goes back and he just tells the skipper, "well, I couldn't make the appointment but I'll see when we get down to Frisco, I'll go to the Frisco hospital," and in many cases, in that length of time, that guy is pretty sick, so if we really appreciate it, in the maritime industry, the amount of time that the administration of this hospital has taken to evaluate and expedite type of care.

Mr. **Little**. Thank you very much, Mr. Denny. Thank you, Mr. Chairman.

The **Chairman**. Counsel?

Mr. **Kyros**. No.

The **Chairman**. Thank you very much.

The next panel is representative of the community services, Ms. Luana Reyes, Seattle Indian Health Board, and Mr. Bill Hobson, Central Seattle Community Health Board.

STATEMENT OF LUANA REYES, SEATTLE INDIAN HEALTH BOARD

Ms. **Reyes**. Good morning, Mr. Chairman and Congressman Lowry and staff.

I am pleased to appear before this committee to present testimony on H.R. 6176 to amend the Public Health Services Act. My name is Luana Reyes, I am executive director of the Seattle Indian Health Board, and appeal in that capacity today to talk about our relationship with the PHS Hospital here in Seattle, but I am also the chairman of the board of directors for the American Indian Health Care Association which is a national organization of 41 Indian health programs located in 20 States. Some of those cities also have PHS Hospitals, and Clinics. I have submitted my statement for the record, and I think I will just summarize that statement. And maybe elaborate a little on some of the information that I have already provided.

The relationship of the Seattle Indian Health Board goes back about 10 years, when the Indian community in the city of Seattle became weary, really, of trying to seek and secure health care services for urban Indians and Alaskan natives living in Seattle, in King County, in the private sector. At that time the population of the Seattle King County Indian community was estimated to be approximately 12,000 people. A large majority of them had no access to health care, partially because of Indian Health Service policies, which prohibited delivering services to Indians living in urban areas, and partially, largely I think, because inadequate income to purchase care from the private sector. After many years of trying to secure care in the urban areas, the Indian people across the country really decided to provide it themselves. In the city the Seattle PHS Hospital was really the only hospital that responded in a positive way to help us do that. We started an Indian free clinic here in the hospital, in a space that wasn't used during the evenings. And began to deliver medical clinic services by using volunteers three evenings a week.

During the early 1970's when we were developing our program and trying to identify the Indian population in this area, and the extent of their health care needs, this hospital was under threat of closure. That issue is the one issue that affected the relationship of the Seattle Indian Health Board and the PHS Hospital more than any other issue since. It is also the reason why the situation as it exists right now, between the Seattle Indian Health Board and the PHS Hospital, is such a positive one. Both agencies have learned a lot about each other in the last 10 years. I have provided in my statement, I think, a brief chronology of events in the development of the Seattle Indian Health Board, that indicates what can happen when positive efforts are made by community organizations and Federal agency hospitals in seeking to do something about improving the health care of a very needy population. I think that the imagination and creativity demonstrated by the Indian community and the other communities as well, has made it possible for the large number of people who delivered testimony this morning to say the things that they have said. All these positive things have evolved from those early community-hospital relationships.

I have also provided some information in my statement about the role of the PHS Hospital in delivering health care to Indian people, partially to explain why it is that the Seattle Indian Health Board has succeeded so tremendously in developing a primary health program here on the hospital campus. Indian people in the three-State area of Oregon, Washington, and Idaho, do not have access to an Indian Hospital, there is none here in the Northwest area thus the PHS Hospital has been identified really by Indian people as their hospital. Indian tribes in the 3-State area number approximately 39 tribes with 9 of them being in the Puget Sound area and most of their inpatient care is secured here at the hospital. The Indian Health Service has a contract health service program, through which they purchase care for eligible Indian people who live on federally recognized reservations. A large part of that care is purchased here at the hospital, as well as other community hospitals in the three States depending upon the patient needs. Many of the Indian people who had previously received care through the PHS Hospital, as members of federally recognized tribes, now live in urban centers in and around the Seattle and the Puget Sound area and have identified this hospital, over a long period of time, as the hospital where Indians receive care.

Because of that, the urban Indian health program found it easier to identify our population. We provide the primary care, and refer patients on a regular basis to the PHS Hospital for in-patient specialty care. The impact of the primary care services, that we deliver at the Seattle Indian Health Board, is shown and demonstrated on page 3 of my statement. I include that information to indicate to the committee the progress of the community programs. We are not only interested in delivering more and more services and counting heads in an effort to continue our reason for being. We are concerned about whether or not the services we deliver make a difference and in the Seattle Indian Health Board, largely through the cooperation of the Federal institutions working with us, we are able to show in at least three areas that the care we deliver, and the care that the hospital delivers, is making a difference.

Our ability to demonstrate any impact at all has relied heavily on the fact that we deliver sensitive care to a population that requires recognition of cultural values, and that in turn depends upon our ability to maintain a network of services, of which the PHS Hospital has become an integral part. We cannot do without the hospital.

Our emphasis on primary care really serves to reduce admissions to this hospital which is a new style of health care for Indian people. Historically they have waited too long to seek health care, and thus have had no options available to them except very expensive hospital care.

In 1979 our records indicate that about 350 Indian people were referred for inpatient care at the PHS Hospital, about 1,400 patients received specialty care accounting for about 5,000 patient visits, in specialty clinics here at the hospital. The final point that I really want to make really is in conjunction with the draft amendment language that would require some payment mechanism or payment requirement for the medically underserved. One of the reasons for the establishment of community health programs, specifically Indian health programs, was to remove the barriers to health care that existed and effectively prevented Indian people, and other poor people from seeking and securing health care in the private sector. The cost of health care is still terribly high and still effectively prevents us from securing health care for our population in the private sector.

If the draft amendment language is accepted requiring our population to begin to pay for services, based upon ability to pay, the barrier is back in place again and 10 years of effort will have gone down the drain. I also would like to elaborate a little on the difficulty of setting up third party payment mechanisms. As a community health center NHSC site, funded by other HEW funds, the Seattle Indian Health Board has developed third-party-payment mechanisms to recover reimbursements to the full extent that our patients are eligible for medicaid and medicare. It may be interesting for you to know that of the 15,000 Alaska and Indian Native patients who regularly use the Seattle Indian Health Board programs services about 67 percent of that population are really part of the working poor, their income makes them ineligible for medicaid and yet does not provide them with adequate dollars to pay for health services. The cost of setting up such a billing system within the hospital system may really be more costly than the amount of money that is eventually recovered. And thus, we would ask the committee to seriously consider not requiring that kind of patient payment mechanism for the medically underserved in this hospital, but rather only collect from third-party payers, such as medicaid and medicare and other private insurers.

For your information, of our patient population, approximately 23 percent are eligible for medicaid, 3 percent are eligible for medicare, and 4 percent have private insurance, 7 percent are covered by Indian Health Service, contract health services, and then the remaining 67 percent have no payment source. As an added note——

The CHAIRMAN. You would have all of this care provided on a free basis?

Ms. REYES. Yes, recognizing that not all of the 67 percent of our patient population uses the hospital for inpatient care, only a small percentage of our population uses the hospital for inpatient care. Some of the inpatient care that our patients need is provided by other community hospitals, for example the PHS Hospital doesn't have a pediatrics inpatient service, and doesn't have an obstetrics service. Other community hospitals are used for that purpose, and payments to those hospitals are either based on an ability to pay, or the hospitals also collect third-party payments. Our social service department educates and helps our patients in establishing payment mechanisms when they have to go outside the PHS Hospital.

One added comment that has nothing to do with my testimony at all, just something I noted this morning as I heard some of the other people testifying. You've heard testimony that the PHS Hospital is really of critical interest to other institutions in this city, particularly the training institutions. I would submit that it is because of the patient diversity, accounted for in the inpatient population coming from community programs, that causes the PHS Hospital to be so important to those other institutions.

Thank you very much.

The **Chairman**. Thank you, Ms. Reyes.

STATEMENT OF WILLIAM D. HOBSON, SEATTLE'S COMMUNITY CLINICS

Mr. **Hobson**. Chairman Murphy and Congressman Lowry, ladies and gentlemen of the staff, and concerned citizens with us today. My name is William Hobson, and I am speaking this morning on behalf of the Seattle's community clinics.

I am an administrator for five clinics system that provides primary health care services to low income people in the greater Seattle area. It gives me a great deal of pleasure to speak on behalf of Seattle's U.S. Public Health Service Hospital.

I have this feeling because the staffs, boards of directors, and patients of Seattle's community clinics are in general agreement that the hospital has voluntarily made a commitment to meet the health needs of low income people in this area. Although confronted with the problems of greatly limited staffing, less than adequate facilities and changes in administration, the Seattle Public Health Hospital has managed to maintain its commitment. The intimate contact between community clinics and their patients leaves little unknown about the quality of care provided and sensitivity to our patients. We know a lot about how this hospital operates and what we know, we feel very good about. We have the highest praise for those things which employees in this hospital can control.

The community clinics' experience with this hospital dates back to 1976 with the initiation of an affiliation agreement. That relationship was formed back in 1971, which was the official time when patients started to be admitted to this hospital from the community clinics.

We are now concluding the third year of an expanded medical care delivery capacity in eight of Seattle's community clinics through participation in the National Health Service Corps program. Statistics show, however, that this hospital sees only 10 percent of our patients. In other words, the community clinics do not "dump" their patients on this hospital but selectively admit only those requiring hospital services. We have devised a workable system to get patients to return to their referring community clinic for further primary care rather than returning to this hospital's outpatient department. Great care is taken in this process as we are especially sensitive to the staff shortage here. We have devised a call system which takes this burden off house staff. We have also been especially careful not to convey the idea of an open door policy to the community which would cause the outpatient department to be inundated. Our experience over the past years has proved to us that a controlled and appropriate use can be made of a U.S. Public Health Service Hospital by community based primary care programs. There is no great secret to the success of this endeavor. Establishment of a well defined relationship with primary care programs which have the capability to provide a full range of primary care services has built in controls. One can make a prediction under these circumstances as to the volume of hospital based services required which is accurate enough to insure against overloading. This is what was done and as we look back over our years of experience we can say this can work well.

The fact that the community clinics of King County have been able to establish a good patient care relationship with this hospital is not the only reason that I am pleased to speak on its behalf today. Over a dozen community clinics send patients here and each is acutely sensitive to the dynamics of health planning. The community boards and staffs of each clinic believe in a high level of involvement by all elements of the population to be served in the planning for services. We can easily see that there are virtually no hospitals in this area which actively seek the input of patients in policy development or voluntarily bring their plans into the public arena for review and comment. The voluntary development of the patient advisory council here at this hospital sent a clear message to our communities that our input was considered to be important. The fact that the patient advisory council has a clear channel to administration and can self-select the areas of concern for discussion is extremely significant. Voluntary submission of this hospital's expansion plans to the local health planning agency while officially exempted was very significant. This was a statement that this hospital believed in a public planning process which we see other hospitals going out of their way to avoid.

The community clinics are not trying to say that the Seattle U.S. Public Health Service Hospital is perfect but that we endorse their endeavors to be responsive to philosophical concerns and practical community needs.

The community clinics would like to see the following:

No. 1, adequate staffing for the Seattle Public Health Service Hospital, particularly in the area of nursing.

No. 2, modernization of the physical plant.

No. 3, special awards to the staffs of those PHS Hospitals which have endeavored to provide a quality program while working under the shadow of termination over the last 10 years.

No. 4, arrangement of a patient billing system that seeks reimbursement of insurance coverage and leaves the decision on any further patient billing procedures with the patient advisory committees.

No. 5, adoption of a specific long-range plan for each PHS Hospital rather than the adoption of a national master plan that assumes that each PHS Hospital should be handled in the same fashion. The flexibility of each PHS Hospital to respond to community needs should be optimized. Standardization diminishes the flexibility required to do a good job for the community.

No. 6, the universal adoption of patient advisory councils in each PHS Hospital to get patient input in the policy development process.

Please take a message to Washington, D.C., that PHS Hospitals are an ideal resource for meeting the needs of special population groups such as Southeast Asian refugees. Please convey to the policymakers that PHS Hospitals can demonstrate exemplary cost containment. Please convey the fact that there truly is a role for a federally supported hospital which is sympathetic to community concerns.

Thank you.

The CHAIRMAN. Thank you, Mr. Hobson. I understand, Mr. Hobson, from your testimony, that the proposed expanded patient load will require considerable extra funding and more flexible personnel to handle this quota mission.

Mr. HOBSON. That is correct. I think we are talking about an expanded patient load with controls. I think we are talking about an expanded patient load that is very carefully planned, all over a period of time, that really doesn't provide a significant burden to the hospital. In terms of additional resources, I think we are talking about, first of all, bringing the hospitals up to the staffing needs that exist currently today. We don't have plans here in Seattle for instance to bring in a large additional number of people to be seen here at this hospital. I think we are talking about a system of about 14 community clinics that are already sending their patients here. We feel that if there was adequate staffing available, to meet the position ceilings that already exist, it would take much of the burden off the system as it is today. We really wouldn't have a staffing crunch or additional needs.

If we talk about bringing the level of staffing to just an adequate number, that would be required for good patient care, here in this hospital for the existing number of people, I think that need could be met, so I think we are not talking about greatly increased resources. We are talking about just increased resources to meet the needs that are currently existing here in the hospital.

The CHAIRMAN. Why don't the independent clinics send their patients to the county hospital?

Mr. HOBSON. That was the intent a number of years ago. The community clinics looked to establish a contractural relationship with one hospital, and we wanted to do that because for physicians who are on our staffs it is quite a problem to have patients hospitalized in a number of of different hospitals. It is to our advantage for continuity of patient care, for adequate referrals, for essential travel time of our physicians to establish a relationship with one hospital. The community clinics went to a number of hospitals in this community in an attempt to establish a working relationship for inpatient care services, extensive lab and diagnostic workup services. The county hospital at that time had declined involvement to that level. They declined to enter a contractural arrangement in Seattle community clinics for providing health care for their patients on a standard referral basis. The director of this hospital, Dr. Will Johnson, volunteered under a clause in this hospital's regulations, that allowed him to provide a reasonable volume of care to low-income people in the community. And it was this hospital that first extended an invitation to Seattle community clinics to fulfill that role—essentially that is why we are here today—because that role has worked out well. And we have furthered our relationship with this hospital.

The CHAIRMAN. Does this State run a hospital system that provides care for mental retardation and for mental health?

Mr. HOBSON. The State has some systems but I think that they are mostly specialty hospital systems, such as the mental health, and the mental health area.

The CHAIRMAN. If someone came to one of the community clinics for a mental health problem would you refer that person to the State facility for medical care?

Mr. HOBSON. Certainly, the community clinics have a wide range of referral resources, and only certain segments of the referrals that we make actually go to this hospital.

As you have heard mentioned earlier today, we have a backup arrangement with the Virginia Mason Center that can provide the tertiary care that we need for some of our patients, for services that aren't normally provided at this hospital, for those services that this hospital has a long waiting list, for services such as deliveries that aren't provided at this hospital, we do send people to other resources for care, in mental health we have a separate referral system, where we send our mental health patients to a number of other facilities, both community based facilities and State run facilities. The mental health staff here at this hospital is very small, and we don't—well, we attempt to not overload any particular service in this hospital that has particular staff shortages, they are having some problems already just meeting the need for the primary beneficiaries.

The CHAIRMAN. What is the occupancy rate in the other hospitals?

Mr. HOBSON. I am not familiar enough with the occupancy rate in the wide variety of hospitals that we have here in Seattle, to comment on.

The CHAIRMAN. Could you tell us in general terms?

Mr. HOBSON. I have heard that the occupancy rate of some of the private hospitals is not real great, it—they are not very full. I really wouldn't want to venture a guess as to what that is, since I don't have any definitive information on that.

The CHAIRMAN. When you have an emergency case at a clinic, do you send that patient here?

Mr. HOBSON. We have taped recordings at our clinics, based on our clinic telephone system, that request people in the event of an emergency, to call the emergency room here at the Public Health Service Hospital, we have an oncall system from our obstetrical patients and for our chronic care patients, so that those patients that require just some attention from our staff physicians will be contacted via the switchboard here at the hospital, and can therefore give our patients a call directly, so we make limited use of the emergency services here at this hospital.

The CHAIRMAN. Mr. Lowry.

Mr. LOWRY. Miss Reyes, do you interpret proposed legislation amendment to require third party payment for medically underserved, is that the way you read that?

Ms. REYES. Third party payment for the medically underserved, and those who do not have third parties, I interpret the amendment to read that the patient will be billed on a sliding fee scale, and that is the part that we would find objectionable.

Mr. LOWRY. The sliding fee scale based on the ability to pay?

Ms. REYES. You will find that most of them have no ability to pay, that's why I commented that the cost of setting up the mechanism might be more than they would be able to cover.

Mr. LOWRY. Thank you.

Bill, what do you think the nursing staffing ratio is in this hospital, how well is it meeting the need?

Mr. HOBSON. What I have to go on there, Congressman Lowry, is just the feedback that we get from our patients as well as from some of the staff of our community clinics who work directly with the patients here on the wards My understanding is that the nurses, although really committed, are just really under stress, because of the limited availability of nursing time here on the wards, in terms of the specific ratios I wouldn't be able to quote a figure on that but in terms of the outpatient volume, I think that, well—excuse me—the inpatient volume, that we would need some additional nursing staff. I haven't seen a definitive study citing a particular number of nurses that would be required to bring this hospital up to a level of parity with other hospitals. However, I think that the administration of this hospital probably could provide you with a figure that would be required. That would enable the nursing staff to not adequately meet the needs of the wards.

Mr. LOWRY. Do you have any ideas how many hours would work on an average day or week?

Mr. HOBSON. No, I don't. I am not familiar enough with the inpatient dynamics here to really quote you a definitive figure on that.

Mr. LOWRY. Thank you.

The CHAIRMAN. Mr. Kyros?

Mr. KYROS. In your testimony, on page 3, you revealed an interesting fact about how incidents of hypertension are three times higher with the Indian-American population than the national average. What possible reason is there for that; is it diet, hereditary, or what?

Ms. REYES. I think it is a little of both. Diet and heredity. In various parts of the country studies are being done on incidences of diseases among Indian populations. Hypertension is very high in all Indian populations, particularly high in our population here in the Seattle-King County area. Diabetes is another high incidence disease, particularly among some of the Southwest Indian tribes. The reasons aren't entirely known, but there is no question that nutrition has something to do with the high incidence. We say that because nutritional counseling and nutritional education has had an impact on the positive results of our hypertension program.

Mr. KYROS. Thank you.

The CHAIRMAN. Thank you, Ms. Reyes and Mr. Hobson.

[Panel excused.]

[Applause.]

The CHAIRMAN. The next is a panel from the PHS Hospital, Mr. Thurston Muskelly and Mr. Bob Kaplan.

STATEMENT OF THURSTON MUSKELLY, UNION REPRESENTATIVE, PUBLIC HEALTH SERVICE EMPLOYEES, PUBLIC HEALTH SERVICE HOSPITAL

Mr. MUSKELLY. My name is Thurston Muskelly. I am a local union president of American Federation of Government Employees. And I represent nonprofessionals and professional employees.

If I had known about the statement from the Department of Health, Education, and Welfare before I wrote my speech, I would have changed my speech. I wanted to call your attention to paragraph No. 2 on page No. 1; paragraph No. 2 on page No. 2.

I want to welcome the chairman of the committee and also the supporting staff and Congressman. We have been in this fight a long time and I am glad to see Congressman Murphy here at this hearing, and since 1971, 1972.

I dispute the testimony of Department of Health, Education, and Welfare, as I said, section 2, paragraph No. 2, and paragraph No. 2 of page No. 2. We are not meeting the compliance of public law. Public Law 93-155 at this present time as a U.S. Public Health Service Hospital. And the thing that really makes me very angry about this situation is that Dr. Erickson was a director of this hospital for 18 months, prior to his promotion to Washington, D.C. And the constraining problems of the PHS Hospital—that the directors of these hospitals have to comply with the methods that are handed down from the Bureau of Medical Services, to comply with these public laws. I am very unhappy with that statement, and I am sure the employees of the hospital, after they read the statement, are very unhappy with them.

Mr. Chairman, I will go to my speech, but I just wanted to make that a matter of record. I have been wishing for this opportunity to speak at the committee on problems of the PHS Hospital and the staffing of PHS Hospitals.

Mr. Chairman, honored Members of Congress, we are very glad you are here today. Welcome to the great State of Washington.

The employees and the union have become increasingly concerned about the patient care at this hospital. We have expressed our concerns to Bureau of Medical Services and leaders of this hospital about how the patients are in danger, as well as the employees involved with patient care, because of lack of adequate staff. Bureau of Medical Services has stated the hospital is adequately staffed to take care of the patients and this has long been disputed by the nursing staff and other support staff.

The nurses claim the ratio of nurses to patient care is less than 2.5 hours per patient. The American Nurses Association has expressed that the minimum standard is 3.5 hours per patient. At this time the present staff could not give adequate care to 130 inpatients. We have been understaffed for nurses the last 2 years, and for 2 years management has insisted we have had adequate staff.

The employees at this hospital feel we can only support the proposed legislation for accepting more beneficiary groups to be served at this hospital if the increase in beneficiaries is simultaneously accompanied by a proportionate increase in staffing. The Bureau of Medical Services hires employees for 700 hours to 1 year to help take care of the patients. We train these employees for this amount of time and about the time we feel they are able to take care of a patient's needs, his or her tour of employment expires. We want career-conditional employees.

This hospital could be a living model for medical services for the poor, underprivileged, and refugees if Congress would make the Bureau of Medical Services provide adequate staff to meet the mission of this hospital. Congress should take the staff ceiling away from the Bureau of Medical Services and see that a 220-bed hospital's needs are met with an adequate staff.

I recommend that No. 1, Congress should set the ceiling for staffing of these hospitals, and No. 2, Congress should investigate these hospitals on site to see if these staff ceilings are mandated to adequate staffing.

If Congress and the American people want these hospitals to be a model to the underprivileged American people, then we must be assured that these people will receive the best medical care at a low cost to the American people and that their lives are not in jeopardy because of lack of medical care.

These hospitals could be a living model for national health care if we had the staff to prove to the American people that health care is a service and not a profitmaking machine.

The CHAIRMAN. Thank you, Mr. Kaplan?

STATEMENT OF ROBERT KAPLAN, CHAIR OF THE PUBLIC HEALTH CARE COALITION, AND CHAIR OF THE PATIENT ADVISORY COUNCIL, PUBLIC HEALTH SERVICE HOSPITALS, SEATTLE

Mr. KAPLAN. Good morning. My name is Robert Kaplan and I am the chair of the Public Health Care Coalition and the chair of the Patient Advisory Council at the Public Health Service Hospital in Seattle.

It is very satisfying to have Congress here today to consider expansion of the Public Health Service mission. From 1971 to 1973, we fought an uphill battle just to keep our PHS Hospital open. We succeeded, thanks to the grass roots support of Public Health Service beneficiaries and employees. During our initial years we stuck together against all odds, and, with Senator Magnuson and this committee in the lead, Congress responded by maintaining the PHS Hospital. Since 1973 we have worked to implement our coalition's ambitious program to improve and expand the hospitals and their mission. In fact, that program has been the key to our success even in defending the hospitals against closure. For it was the Seattle hospitals' assistance to the community clinic patients who had nowhere else to go for hospital care which has aroused massive community support for this facility. The public sees the PHS as a vital resource for the general public welfare.

There also was and remains a compelling economic case for the Public Health Service. Government studies have repeatedly demonstrated that there is no more economical way than the Public Health Service for the Government to provide legally mandated medical care. The Public Health Service provides quality services at a cost variously estimated to be between one-half and two-thirds of the cost of comparable services in the private sector. The economics of public sector versus private sector medicine is the issue which underlies the continuing PHS controversy. The Public Health Service has a vital role to play in the future of our Nation's health notwithstanding the view of former HEW Secretary Elliot Richardson expressed when he told us in 1972 that "The Government should not do anything someone else can do for a profit."

On the horizon is a national health plan which will hopefully guarantee that no one will go without health care for lack of money. Enactment of such a plan has been stalled by the mounting fear of the price tag. While our coalition feels that the health of the American people should be a much higher national priority than it has been, we agree that a national health plan could break the bank if the approach is simply to subsidize private medicine and to extend coverage to all citizens. The profiteering and inflationary record of the medical industry, especially after the availability of public medicare-medicaid funds, has been outrageous. The risks of price gouging and inadequate service will be far greater if private interests can achieve a monopoly over the delivery of health care in America. Private sector health costs need a public sector by which to be gauged. Additionally the PHS can provide and promote progressive innovations in health care organization and delivery, in research and training, and be guided by the public interest and not by private gain. But to be most effective in these ways the Public Health Service should have more resources and a clear mandate for an expanded mission.

We wish to give our wholehearted support to the proposals to extend PHS eligibility to retired seamen, families of seamen and the medically underserved as was recommended by the 1978 HEW task force on the PHS. Our Seattle hospital has shown that the PHS can serve a broader population economically and at the same time improve its service to maritime and other Federal beneficiaries. We have shown that the PHS can play a catalyzing role in coordinating federal and public agencies; and elements of the private medical sector and grassroots community groups to meet the needs of those who have been prevented from obtaining health care for economic, cultural, geographic, and other reasons.

But, the PHS system must get relief from understaffing. The system is stretched to the breaking point. Last October a top level HEW report showed the PHS to be overall 15 percent understaffed and 38 percent understaffed in the critical area of nursing. We support an expanded beneficiary population for the hopsital but we know this will require more staff and also renovations and expansions of the existing facilities.

We support increased staffing, we need increased staffing. Some may ask if we can afford to pour more resources into a public health service. I feel the proper question is: Can we afford not to expand the role of such an institution? Its medical potential and economic savings have already been demonstrated. It would be penny-wise and pound-foolish to cutback on the PHS. Expanding the PHS mission will bring extra dollars into the system. The HEW task force concluded that understaffing was the main deficiency in the PHS system and recommended that to allow more flexibility in meeting the actual patient care needs congressional personnel ceilings be removed. We agree and we condemn the false economy of understaffing which results in more Federal dollars being spent on buying costly private sector services for Federal beneficiaries. Even worse, the false economies can result in compromising the quality of care and posing a direct threat to patient safety.

Let me conclude by saying a word about the Patient Advisory Councils. Our Seattle Advisory Council recommends that Congress provide a legislative mandate for beneficiaries involvement in governing their health system through advisory councils. The PHS created local patient advisory councils in 1977 in a response to grassroots pressures for democracy in the PHS system. This is a step in the right direction but without a legislative mandate the patient advisory councils will not gain either the authority nor the resources they need to be genuine partners in planning the future of the PHS. Such an involvement of those served by the PHS will prove to be essential in realizing the potential of the PHS to serve the Nation through its expanded mission.

I thank each of you for your support for the legislative proposals in Congress: Expanding the mission and providing for increased staffing and for renovations of the hospitals.

The CHAIRMAN. Thank you, Mr. Kaplan.

Mr. Muskelly, in the House Appropriations Committee's Conference Report of June 12, 1979, this is after the Appropriation Bill had been finished, the intent of this Congress was stated clearly by asking HEW to come back to Congress to ask for increased funding to implement the Advisory Report recommendations; but as of today HEW hasn't submitted its request to us. So we find it difficult for the Congress to act, as you clearly want us to act, if HEW won't submit a funding request to implement the Advisory Committee's plans. But what do we do? We have an executive branch to implement the law. What we must have are those recommendations from HEW. We are working on the Secretary, as we have been, as you know, for the last 15 years. Unfortunately, the Secretary is in the process of being screened by the Office of Management and Budget, which works directly under the White House. The Office of Management and Budget is the redliner. They don't manage, they redline. And of course the President gives them the instructions to cut the budget, balance it, and they just go right across the budget with a meat ax and red pencil. Always the Public Health Service Hospitals and Clinics get the same treatment as everybody else, when that redline comes out. This is one of the reasons why the Secretary does not come back to us with what she is requested to and that is the reason we are here. We will continue to ask the Secretary to "let us have your recommendations sent directly to us."

Mr. MUSKELLY. Mr. Chairman I agree with you in some context.

The CHAIRMAN. I didn't expect 100-percent agreement.

Mr. MUSKELLY. I agree with you in some context. But I don't believe that the law and 93-155 is within compliance, say within these hospitals, 1971-72, Senator Magnuson put this law in effect. If you go back to the mandate of records you will see that more contracting of facilities of health care that these hospitals are supposed to be taking care of, are being contracted out, they are not meeting the compliance of 93-155. Personally the employees of this hospital feel that Congress should make the Bureau of Medical

Services, or HEW Secretary, and meet the mandate of 93-155. For instance, since HEW believed in specifics, and I dislike that word specifics, the problem is in 1971 and 1972 we had a pediatrics hospital in this hospital, but a pediatric ward in this hospital. We have now a pediatrics system in this hospital, but if it is any inpatient care, it has to be contracted out to orthopedic hospital, this is one of the factors. Then one of the factors is a lot of our medical care delivers with the nerve system, and I am not too much medically inclined, I am just a layman, just speaking on these terms, this type of work is contracted out to other hospitals, that deals with the brain and the spinal cord, and this type of stuff. According to 93-155 all of these services should be provided at this hospital. As of 1972, or whenever the law was implemented, and now HEW has come back to Congress and said "we are taking care of our beneficiaries groups," but these medical care problems were being taken care of at this hospital and not being taken care of at other private concerns, and this is why I am expressing my point on 93-155.

The CHAIRMAN. We've had extensive oversight on these hospitals, as you know, over the years. One of the first things that popped up, like a red herring, or salmon, if you will, was this contracting out of services. If HEW sets the policy for the hospital, then HEW decides to contract out security services, to contract out housekeeping, to contract out of the maintenance work, and to contract out numerous other things. All of a sudden you've got a hospital standing there with nothing but a lot of contracted out services. All its services are being provided elsewhere. Then HEW says, "Well, let's just turn these contractors over to the city of Seattle, or the University of Washington." And then they have accomplished over a period of time, with a small sleight of hand, what they could not have accomplished up front: the closing of the hospital.

Mr. MUSKELLY. This is what we want you to try to stop.

The CHAIRMAN. We've got our eye on that. And the people in HEW know it, and they know it very well.

Mr. MUSKELLY. The problem is another thing sir, that all of the problems that HEW presents to Congress, is a mere report of paper work. Health Service Administration is a body of paper work. You can come up with a number of programs that are supposed to be implemented into these hospitals, and its mere paper work, its a desk weight, must I say, or maybe it is something to hold down the garbage can. And these are the things that employees in this hospital feel that Congress should look into, and see that these things are really mandated to the full potential.

The CHAIRMAN. Mr. Kaplan, we've had many statements, including the statements of this panel, that this system provides a pretty good yardstick by which to measure medical costs, in almost all medical areas. The Public Health System can give you the cost of a blood analysis, laminectomy, bed cost, and the physicians cost. How does the HSA and the others in the medical community like the idea of this cost comparison yardstick?

Mr. KAPLAN. To the best of my knowledge, the HSA has not used this cost comparison as a basis for any determinations that they have made. I don't think the private medical sector likes the comparison, because it indicates that services can be provided in a much more economical way and that's why I go back to my statement that what you do when you cut the PHS budget, is to inflate the need in other budgetary categories, such as medicare. Because if medicare beneficiaries are receiving their care here, even if there is coinsurance; the cost here is less than the Government would pay with the full insurance. So we feel by expanding the mission we are going to be cutting into the 60 to 70 percent of the budget, which everyone says you can't cut into, because it is fixed. These are obligatory expenses that we have. We feel we can cut into those by spending money with the PHS and we can cut those expenses.

The CHAIRMAN. In our National Health Insurance debates, we run across different recommendations by H. & C., as well as the Kennedy-Corman plan. What we find is that almost 20 to 40 million people in this country cannot afford medical care. Who is supposed to provide this medical care to them?

Mr. KAPLAN. As a society we can let them die in the streets, or we can in some way start providing them with medical care.

The CHAIRMAN. Who is going to provide it?

Mr. KAPLAN. I think that all levels of government have to assume some responsibility.

The CHAIRMAN. Government.

Mr. KAPLAN. I think the private sector has assumed some responsibility and the integrated system can work to provide for the needs, of these millions of people, that are not being met. I don't think that there is an easy answer, but I think that society as a whole has to assume some responsibility for those unmet needs, and it has assumed a role through medicare and medicaid payments, to a certain extent.

The CHAIRMAN. About 20 percent are not covered.

Mr. KAPLAN. I think what we have tried to do in Seattle, is we have tried to use all sorts of funding, Government, private, foundation funding, and Government and private resources, combining the Virginia Mason experience with the PHS experience here. I don't think the private sector is willing to assume the responsibility, they have not shown themselves to be willing to assume that responsibility. But I think with some leadership from Government, they can assume a greater degree of that responsibility. I think that it is all of our responsibilities, and therefore I think that the bottom line is that some way care has to be given, and I think the leadership is going to have to come from Government.

The CHAIRMAN. The figure mentioned today, I think was $806 per capita being paid for medical insurance in this country. That is enough to buy three times the medical care necessary for the people in this country.

Mr. KAPLAN. I am not going to dispute that, I think what you are pointing out is that there is a misallocation of the health care dollar, and I think that there should be a greater use of the PHS's for health care expenditures, and I think one of the things you are pointing to is that perhaps the private insurers should look toward PHS as a greater gage on their medical costs, and what is a reasonable fee to charge for a service provided.

The CHAIRMAN. But don't try to establish the cost by a Federal program providing medical service, or you are going to get the ire of the greatest lobby operation in history.

Mr. KAPLAN. We have been receiving that ire.

The CHAIRMAN. And I know it. Mr. Lowry?

Mr. LOWRY. First of all I want to say I'm impressed about how the merchant marine—some one from merchant marine or West Point knows so much about health. Bob you mentioned 1973 and back to the law, 93-155——

Mr. KAPLAN. Public Law 93-155.

Mr. LOWRY. You went by it pretty fast, in your opinion what is the level of staffing equivalent to 1973?

Mr. KAPLAN. I think that in all honesty I will have to ask Dr. Erickson that. Because I don't think that the important thing to look at is in October 1979, the Assistant Secretary for Management Budget, the Department of HEW, issued a report indicating the figures that we have given, 15 percent and 38 percent, in nursing and I think we were hearing horror stories back in 1973 but I don't think that we were talking that much understaffing in 1973. And this is a guess.

Mr. LOWRY. But the patient advisory council didn't exist then?

Mr. KAPLAN. Yes.

Mr. LOWRY. Were you associated with some sort of a citizen way with the hospital?

Mr. KAPLAN. I have been associated with the Public Health coalition well before 1973.

Mr. LOWRY. What was your feeling, I was actually looking more for your subjective feeling of the level of staffing within this institution.

Mr. KAPLAN. Can I ask Thurston, who is here, and Thurston, well, I would have to abide by Mr. Muskelly's feelings on that, I think he has indicated that he doesn't think the staffing level is adequate as it was in 1973.

Mr. MUSKELLY. I think the staffing was adequate in 1973, but I think as the trend of medical care and the needs of the beneficiary groups of the hospital grew, then the staffing was inadequate at this present time. Because we had a dilemma that was stating that the hospitals were going to close and we didn't have that many beneficiary groups coming into the hospital, in other words, as you remember, a man got up here and said that the fishermen were a little leery about coming to the hospital, and the seamen, and other beneficiary groups had the same idea about the hospital, and I think this brought on a big problem at the time. I know that BMS is going to say well, we had the same number of people allocated at that time, with the same amount of staff, but the staff was not in the position, in other words the title of the staff was not in a position like it is now. We have eliminated a lot of staffing and that is why expressing 700 hours to a year employment, that is what BMS is using at this present time, to do that.

Mr. KAPLAN. I think this is looking backward. We should be forward looking, as to what is adequate staffing, not what was staffing back in 1973. Or 1972.

We have to look at HEW's own reports, and there isn't adequate staffing, and somehow there has to be an increase.

Mr. LOWRY. Mr. Muskelly, I am not familiar with the 700 hours would you explain that? I noticed in your written statement, but I just didn't follow that at all.

Mr. MUSKELLY. 700-hour employee Health Service Administration, the Bureau of Medical Service, of the Federal Government, and the taxpayer says "save some money". And by saving money we use the 700-hour employee—700 hours or a year. That 700-hour employee does not contribute into retirement, does not contribute into insurance, does not have the other benefits of a career-conditional employee. So at one time or another the Bureau of Medical Services has anywhere from 45 to 35 employees marching out of this hospital at one time, because their appointment has expired. So then it brings a dilemma and hardship, or whatever you want to call it, mental and physical hardship on the old employees to retrain these 35 or 40 employees, that it is just like a shift coming in and out. Every 700 hours or a year.

Mr. LOWRY. Where do they go?

Mr. MUSKELLY. They work for these private concerns, like the Federal Government subsidized Job Corps, University of Washington, which is the nurses corps, and this type of stuff, it supplements programs that they use to subsidize for people to take their patients in this hospital. They come from all groups of life, but there is only one thing, it creates a hardship on the old employees in the hospital, by the time we feel that they can produce good medical care, it is time for them to terminate.

Mr. LOWRY. Thank you.

The CHAIRMAN. I want to thank you gentlemen. We certainly appreciate your contributions to this hearing. This will be the conclusion of our hearing.

Mr. LOWRY. I think it was excellent testimony. We didn't hear from the Director of the hospital, I guess that was planned, but considering all the financial handicaps that the hospital is under, the service is tremendous. And we certainly want to thank you for the hospitality of providing the room here for our hearing. Mr. Chairman, thank you very much again, for you, and the Committee's attention.

The CHAIRMAN. The whole problem of medical care is probably one of the vital elements in our country. So many times we hear people say, "Well, you can always go back to Great Britain, and socialized medicine, as with other European countries." Of course, we don't think you have to socialize an industry in order to make it work more efficiently. I think we have found in many instances that it works far less efficiently, once you put Government constraints on things. But we do have a great responsibility to the American people and it is up to all of us to assume our proper responsibility, whether we are in the Government, or the private sector, or industry, to work toward resolving these problems.

I just want to congratulate the people who have traditionally served on the staff of this hospital, and the community, for being so far sighted as to almost integrate what should be the pattern for all these hospitals. If the Seattle lesson has been learned across the country by the other seven hospitals, with the exception of Boston—you know how independent those Yankees are up there—then we are certainly going to be way ahead in providing services to the community in which these hospitals are located, as well as providing quality medical care to the PHS beneficiaries and dependents.

Doctor Tompkins, I think you run a very fine instutution here. I think it is because of the people in this area; they are willing to cooperate, and have elected good officials for the past 30 years. Look who you've got over in the Senate and look who you have here in the House. You can't help but win with that kind of a combination. With those words we'll say that the committee stands adjourned.

[The following was received for the record:]

SEATTLE, WASH., *April 6, 1980.*

RICHARD TOMPKINS, M.D.,
Director, U.S. Public Health Service Hospital, 1131—14th Avenue South, Seattle, Wash.

DEAR DR. TOMPKINS: I just learned about the Congressional Hearing regarding the fate of the U.S. Public Health Service Hospital. The Seattle U.S. Public Health Service Hospital is more than an institution. The services rendered to persons referred there as well as the many diagnostic and other procedures for treatment cannot be measured in dollars and/or nunbers.

The hospital stands as a guardian for health care in the Pacific Northwest. I recall in the forties your doctors aided us at the Puyallup Fair Grounds Assembly Center where 10,000 persons of Japanese ancestry were huddled when evacuated from their homes. Since then, in my nursing contacts I have become familiar with the various medical care given to persons in the community.

As Chairperson of the International District Health Center, Board of Directors, I have also received many favorable reports to our patients.

I strongly oppose the closing of this institution and join others in their efforts to keep the doors opened.

Very truly yours,

CATHERINE NATSUKO CHIN, R.N.

[Hearing adjourned at 12:20 p.m.]

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